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Health History Form

The following profile information is required for all clients to correctly evaluate individual needs while taking into consideration any health issues and/or concerns. This information is completely confidential and will be used strictly for the purpose of your individual treatment at Amenity Day Spa.

First Name: _____ Last Name: _____ Nickname: _____

Date of Birth: _____

- 1. Are you currently, or have you within the past year been under a physician's care? Yes No
- 2. Have you undergone any surgery within the past 9 months? Yes No
- 3. Have you ever suffered from any of the following:
 - Cancer Diabetes Epilepsy Hepatitis HIV Thyroid
 - Heart Problems High Blood Pressure Hormone Imbalance Hysterectomy Varicose Veins

4. List all medications & vitamins taken regularly:
Medications: _____

Vitamins: _____

- 5. Do you have any allergies? Yes No
If YES, list: _____

- 6. Answer the following
 - Do you smoke? Yes No
 - Have you ever had a chemical peel? Yes No
 - Do you use Retin-A? Yes No
 - Do you use Accutane? Yes No
 - Have you used any other acne drugs? Yes No
 - Do you follow a restricted diet? Yes No
 - Do you exercise regularly? Yes No
 - Do you have a regular sleep pattern? Yes No
 - Have you had your hair frosted, highlighted, or chemically lightened? Yes No
 - Do you wear contact lenses? Yes No
 - Do you have metal implants or a pacemaker? Yes No

- 7. With what temperature water do you cleanse? Cold Warm Hot

- 8. Do you have any specific skin problems pertaining to your face? Yes No
If YES, specify: _____

- 9. Do you have any specific skin problems pertaining to your body? Yes No
If YES, specify: _____

- 10. Check all skincare products you are currently using:
 - Soap Toner Masque Cleanser
 - Moisturizer Scrub/Peel Other (specify) _____

- 11. Have you ever had a spa treatment before? Yes No
If YES, specify: _____

OIL SECRETION

- Do you experience breakthrough, oily shine during the day? Yes No
 Do you experience breakouts? Yes No

MOISTURE HYDRATION

- How much plain water do you consume daily? _____ ounces
 Do you take laxatives or diuretics? Yes No
 How many alcoholic beverages do you consumer weekly? 1-3 4+
 Check any of the following conditions you experience on your skin:
 Flakiness Tightness Obvious Dryness
 Do you use sunblock Yes No
 If YES, what SPF? _____

CAPILLARY ACTIVITY

- Do you burn easily in moderate sunlight? Yes No
 Do you blush easily when nervous? Yes No
 Do you have a tendency toward redness? Yes No

NERVE ACTIVITY

- What do you consider your pain threshold to be? Low Medium High
 Have you ever experienced any claustrophobia? Yes No
 What type of massage pressure do you prefer? Low Light Medium Firm Very Firm
 Have you had any recent injuries? Yes No
 If YES, explain: _____

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- Are there any areas that require special attention? Yes No
 If YES, explain: _____

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- Are there areas of your body that you would prefer your therapist avoid? Yes No
 If YES, specify: _____

Check any of the following to which you have had a reaction:

- cosmetics pollen animals medicine
 food fragrance iodine AHAs
 sunscreen other (specify): _____

FEMALE CLIENTS ONLY

- Are you taking oral contraception? Yes No
 Are you pregnant or trying to become pregnant? Yes No

MALE CLIENTS ONLY

- How do you typically shave? Wet Dry
 Do you experience irritation from shaving? Yes No
 Do you experience ingrown hair? Yes No

My signature below indicates, to the best of my knowledge, the information I have provided is correct and complete, and I have not withheld any information that may be relevant to my treatment.

Client Signature: _____ Date: _____