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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:

_____

Are there any areas that require special attention? ☐ Yes ☐ No

If YES, explain:

_____

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: _____