

SEILER SKIN AND COSMETIC LASER CENTER AND FUSION SPA

NEW SPA CLIENT PERSONAL INFORMATION

Please complete the following:

Date: _____

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Cell: (____) _____

Work Phone: (____) _____ Email _____

Whom may we thank for referring you? _____

Please list all allergies (including medications, food, latex, cosmetics, etc.)

Please list all medication (including herbal, over the counter, supplements/vitamins) you take on a regular basis, or have taken in the last month:

List all operations, hospitalizations and any serious illnesses:

Are you presently pregnant, trying to become pregnant, or breast feeding? Yes No

Have you ever smoked? Yes No How much? _____ How long? _____

Are you still smoking? Yes No When did you quit? _____

Are you currently under the care of a physician? Yes No

Are you currently under the care of a dermatologist? Yes No

Personal physician: _____ Telephone: _____

SKIN CARE & WAXING CLIENT INFORMATION

List any special skin conditions pertaining to your face or body: _____

What skin care products are you currently using?

Face: soap, cleanser, toner, moisturizer, masks, exfoliator, eye products,
 self tanner

Body: soap, shower gel, scrubs, oil, moisturizer, depilatory products, self tanner

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?

In the last three months? yes no

Do you use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products? yes no

In the last three months? yes no

Are you currently using any products that contain the following ingredients:

glycolic acid lactic acid exfoliating scrubs hydroxy acid vitamin A (retinol)

Do you ever experience these conditions on your skin: flakiness tightness obvious dryness

Do you have a tendency to redness? yes no

Do you ever experience oily shine during the day? yes no

Do you ever experience skin breakouts? yes no

Do you ever experience a burning, itching sensation on your skin? yes no

Have you ever had a reaction to any of the following: cosmetics medicine iodine pollen
 food hydroxy acids animals fragrance sunscreens others _____

What are your skin care goals? _____

MESSAGE CLIENT INFORMATION

yes no Do you have diabetes?

yes no Do you experience frequent headaches?

yes no Are you taking high blood pressure medication?

yes no Do you suffer from epilepsy or seizures?

yes no Do you have any contagious disease?

yes no Do you have any rash that can be spread through skin contact?

yes no Are you pregnant?

yes no Any injuries in the past two years?

yes no Do you have tension or soreness in a specific area? Where? _____

yes no Do you have cardiac or circulatory problems?

yes no Do you have numbness or stabbing pains? Where? _____

yes no Are you sensitive to touch or pressure in any area? Where? _____

yes no Have you ever experienced a professional massage or bodywork session?

How recently _____ Do you prefer: light medium firm pressure

I certify that the preceding history statements are true and correct. I am aware that it is my responsibility to inform my service provider of my current medical or health conditions. It is my responsibility to inform my service provider of any changes to preceding information. If I am to enjoy alcohol as part of my experience, I will not hold Fusion responsible for any effects/problems that may occur resulting from alcohol consumption after I leave the spa.

Signature: _____

Date: _____

Technician/Aesthetician Signature: _____

Date: _____