New Client
Yes ____ No ____
Picture Taken
Yes ____ No ____

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment the following questionnaire must be completed. All information is strictly confidential.

PERSONAL HISTORY

Client Name____ Date__________________________

Date of Birth____________________ Age_______________ Occupation______________________

Home Address______________________________ City_____________ State_____ Zip__________

Contact Phone Number___________________ Reminder Text/Email/Both (please circle one)

Cell Phone Company Provider (for reminder texts) ______________________________________

Email address (for our use only)____

Emergency Contact Name & Phone____

How were you referred to us?____

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE? (Please circle one)

I	Always burn, never tan	IV	Rarely burn, always tan
II	Always burn, sometimes tan	V	Brown, moderately pigmented skin
III	Sometimes burn, always tan	VI	Black skin

MEDICAL HISTORY

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

If yes, please explain ____

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

If yes, please explain ____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ◯ Yes ◯ No

Do you have any of the following medical conditions? Please check all that apply.

◯ Cancer ◯ Hepatitis ◯ Skin disease/skin lesions ◯ Thyroid imbalance
◯ Diabetes ◯ Impaired healing ◯ High blood pressure ◯ Hormone imbalance
◯ Arthritis ◯ Seizure disorder ◯ Frequent cold sores ◯ Any active infection
◯ HIV/Aids ◯ Keloid scarring ◯ Blood clotting abnormalities
◯ Cardiac Problems (pacemaker or defibrillator) ◯ Bleeding disorder or bruise easily
◯ Do you take anticoagulants or aspirin
◯ Diseases stimulated by light (epilepsy, lupus) ◯ Diseases stimulated by heat (herpes simplex)

Do you have any other health problems or medical conditions? Please list:

____

Over →

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced.)

◯ Lidocaine ◯ Hydroquinone or skin bleaching agents ◯ Latex ◯ Hydrocortisone

◯ Aspirin ◯ Topical Anesthesia ◯ Other____________________

MEDICATIONS

Please list medications you are currently taking: ◯ Birth control pills ◯ Hormones

◯ Others: ____________________

Have you ever used Accutane? ◯ Yes ◯ No **If yes, when was it last used?**__________

Please List any topical medications or creams you are currently using: ◯ Retin A

◯ Others____________________

SKIN/HAIR HISTORY

Have you ever had laser hair removal? ◯ Yes ◯ No

Have you used any of the following hair removal methods in the past six (6) weeks?

◯ Shaving ◯ Electrolysis ◯ Tweezing ◯ Depilatories

◯ Waxing ◯ Plucking ◯ Threading

Have you had any recent tanning or sun exposure that changed the color of your skin? ◯ Yes ◯ No

Have you recently used any self-tanning lotions or treatments? ◯ Yes ◯ No

Do you form thick or raised scars from cuts or burns? ◯ Yes ◯ No

Do you have hyper pigmentation (darkening of the skin) or hypo pigmentation (lightening of the skin) or marks after physical trauma? ◯ Yes ◯ No

FOR OUR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? ◯ Yes ◯ No

Are you breast feeding? ◯ Yes ◯ No

Are you using contraception? ◯ Yes ◯ No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, or therapist of my current medical or health conditions and update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures. I acknowledge that I have been given the NOTICE OF PRIVACY PRACTICES for Parker Med Spa. I understand that if I have questions or complaints that I should contact the Privacy Official.

Signature ______________________________ Date ______________

I acknowledge Parker Med Spa's 48 hour cancellation policy. A $35 fee, for appointments prior to 4PM, will be assessed for each service cancelled with less than 48 hours notice or a "No Show", after 4PM and on Saturdays the fee is $50 per service. For laser services $35 will be assessed per 15 minute increment of appointments not given this courtesy. Appointments after 4:00PM and on Saturdays (prime appointments) will be assessed a $50 fee per 15 minutes. This fee will automatically be put on your credit card. Should we have no credit card on file, you will be assessed this fee at your next appointment. ~ For the comfort of our guests and the safety of your children, **we cannot allow children in the spa unless they are here for services.**

Signature ______________________________ Date ______________