Vital Energy Services, Inc.

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Confidential Client Health History Form & Consultation:

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Employer: _____ Occupation: _____

Does your job require that you work outdoors? ☐ No ☐ Yes

Referred by: _____

What would you like to achieve from your treatment today? _____

_____

_____

_____

Your Health:

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?

☐ No ☐ Yes, explain: _____

2) Any recent surgery, including plastic surgery? ☐ No ☐ Yes,

Explain: _____

_____

3) Any skin cancer? ☐ No ☐ Yes, explain: _____

_____

4) Have you had any piercings, tattoos, or permanent cosmetics? ☐ No ☐ Yes

If yes, where on your person? _____

5) Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided)

☐ Cancer
☐ Systemic disease
☐ Spinal injury
☐ Hysterectomy
☐ Heart problem
☐ Arthritis
☐ Eczema
☐ Seizure disorder
☐ Headaches (chronic)
☐ Herpes
☐ Immune disorders
☐ Lupus
☐ Blood clotting abnormalities
☐ Insomnia
☐ Skin disease/skin lesions
☐ Phlebitis, blood clots, poor circulation
☐ Hormone imbalance
☐ High blood pressure
☐ Thyroid condition
☐ Diabetes
☐ Varicose veins
☐ Asthma
☐ Epilepsy
☐ Fever blisters
☐ Hepatitis
☐ Frequent cold sores
☐ HIV/AIDS
☐ Metal bone pins or plates
☐ Psychological treatment
☐ Keloid scarring
☐ Any active infection

_____

_____

_____

_____

6) Has your physician discussed concerns about your body temperature? ☐ No ☐ Yes

Explain: _____

_____

7) Do you smoke? ☐ No ☐ Yes

8) Do you follow a restricted diet? ☐ No ☐ Yes, specify: _____

9) Do you follow a regular exercise program? ☐ No ☐ Yes

10) What is your stress level? ☐ High ☐ Medium ☐ Low

11) List any prescription medications you take regularly: _____

_____

_____

12) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

_____

_____

13) Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

14) Do you have Hyperpigmentation (darkening of the skin) or Hypo-pigmentation (lightening of the skin) or marks after physical trauma?

☐ No ☐ Yes, Describe: _____

_____

15) List your daily consumption (in # of cups) of:

_____ Water _____ Caffeine _____ Alcohol

16) Do you experience any problems sleeping? ☐ No ☐ Yes

17) How many hours do you typically sleep each night? _____

18) Do you wear contact lenses? ☐ No ☐ Yes

19) Have you been exposed to the sun or used a tanning bed in the last 48 hours? ☐ No ☐ Yes

20) How frequently are you exposed to the sun or use a tanning bed?

☐ Infrequently ☐ Frequently ☐ Regularly

If you use tanning beds, when was your last visit? _____

21) Do you have any metal implants or wear a pacemaker? ☐ No ☐ Yes

22) Have you ever experienced claustrophobia? ☐ No ☐ Yes

23) Do you suffer from sinus problems? ☐ No ☐ Yes

Female Clients Only:

24) Are you taking oral contraceptives? _☐_ No _☐_ Yes, specify: _____

_____

_____

25) Any recent changes to or from your contraceptive treatment?

_☐_ No _☐_ Yes, If so, what and when? _____

_____

_____

26) Are you pregnant or trying to become pregnant? _☐_ No _☐_ Yes

27) Are you lactating? _☐_ No _☐_ Yes

28) Any menopause problems? _☐_ No _☐_ Yes, specify: _____

_____

_____

29) Are you undergoing any hormone replacement therapy?

_☐_ No _☐_ Yes Specify: _____

Male Clients Only:

30) What is your current shaving system? _☐_ Wet shave _☐_ Electric _☐_ Wax _☐_ Sugar removal

31) Do you experience irritation from shaving? _☐_ No. _☐_ Yes Ingrown hairs? _☐_ No _☐_ Yes

About Your Skin Care:

32) Have you ever had a facial treatment before? _☐_ No _☐_ Yes,

When? _____

33) Have you ever had a body spa treatment before? _☐_ No _☐_ Yes,

When? _____

Massage: _☐_ No _☐_ Yes

Salt scrub: _☐_ No _☐_ Yes

About Your Skin Care - continued:

Seaweed wrap: ☐ No ☐ Yes

Body scrub (with salt or sugar): ☐ No ☐ Yes

Other: _____

34) Which of the following best describes your skin type? *(Please circle one type number)*

I.	Creamy complexion	Always burns easily, never tans
II.	Light Complexion	Always burns, tans slightly
III.	Light/Matte Complexion	Burns moderately, tans gradually
IV.	Matte Complexion	Seldom burns, always tans well
V.	Brown Complexion	Rarely burns, deep tan
VI.	Dark Brown Complexion	Rarely burns, deeply pigmented

35) Do you have any special skin problems or concerns pertaining to your face or body?

☐ No ☐ Yes Specify: _____

_____

36) Have you ever had chemical peels, micro-needling, dermal planing, hydrafacial, laser treatment, microdermabrasion or any other services performed on your face, neck, back by a doctor or esthetician or other service provider? ☐ No ☐ Yes

In the last month? ☐ No ☐ Yes

37) What skin care products are you currently using? *(List brand if known)*

Soap _____ Shower Gels _____

Toner _____ Body Lotions _____

Mask _____ Sunscreen _____

Eye Product _____ SPF _____

Cleanser _____ Night Moisturizer/Cream _____

Day Moisturizer _____ Other _____

Exfoliator _____ Makeup Products _____

Scrubs _____

38) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products?

☐ No ☐ Yes, describe: _____

39) Have you used any of these products in the last 3 months?

☐ No ☐ Yes

40) Have you used an acne medication? ☐ No ☐ Yes

When? _____ Which drug(s)? _____

_____

41) Have you recently used any self-tanning lotions, creams or treatments? ☐ No ☐ Yes,

Specify: _____

_____

42) Have you used any of the following hair removal methods in the past six weeks? ☐ No ☐ Yes,

Circle all that apply…

Sugar Removal ☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing ☐ Stringing ☐ Depilatories ☐

43) What areas of concern do you have regarding your: *(Please circle any that apply and explain)*

Skin:

☐ Breakouts/acne ☐ Blackheads/whiteheads ☐ Excessive oil/shine

☐ Rosacea ☐ Broken capillaries ☐ Redness/ruddiness

☐ Sun spot/liver spot/brown spot ☐ Uneven skin tone ☐ Sun damage

☐ Wrinkles/fine lines ☐ Dull/dry skin ☐ Flaky skin

☐ Dehydrated ☐ Other: _____

Eyes:

◉ Dehydrated ○ Wrinkles ○ Puffiness ○ Dark ○ Circles ○ Other: _____

Lips:

○ Dehydrated ○ Cracked/chapped lips ◉ Other: _____

44) Have you ever had an adverse reaction after using any skin care product? *(Please circle any that apply)*

☐ Rash ☐ Irritation ☐ Peeling ☐ Sun Sensitivity ☐ Breakout

45) Have you ever had an allergic reaction to any of the following? *(Please circle any that apply)*

☐ Cosmetics ☐ Medicine ☐ Food ☐ Animals ☐ Sunscreens ☐ Iodine ☐ Pollen

☐ AHAs ☐ Fragrance ☐ Shellfish ☐ Latex ☐ Drugs ☐ Other: _____

Please explain: _____

_____

_____

_____

_____

_____

46) What SPF do you use on your face? _____ How often/when? _____

47) What SPF do you use on your body? _____ How often/when? _____

48) Have you experienced Botox, Restylane or Collagen injections?

_☐_ No _☐_ Yes Specify: _____

_____

49) Please use this space to complete answers where space was insufficient: *(Please include the number of the question)*

_____

_____

_____

_____

_____

_____

_____

Future Appointments/Contact:

May I call you at your home, work or cell phone number to confirm future appointments? _☐_ No _☐_ Yes

May I contact you via mail/email about future promotions and news? _☐_ No _☐_ Yes

My signature below indicates I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to my skin from any treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof. The treatments I receive here are voluntary and I release Vital Energy Services, Inc. and/or Janet Novotny (Licensed Esthetician) from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____