Client Information Form

Name:_____DOB:_____Date:_____

Address: _____City: _____State: ____ Zip: _____

Phone:_____Email_____

Preferred method of communication: Text ____Email _____ Call____

We show our appreciation for our Client Referrals with a $50 credit toward an in-office treatment.
Referred by: _____

Emergency Contact:_____Phone Number:_____

Please indicate the services and areas of interest:

Dermal Fillers		Mesotherapy	
Botox		Acne	
IPL		TCA Chemical Peel	
Laser Hair Removal		Anti-Aging	
Fractional CO2 Laser Treatment		Scar Removal	
Microneedling with Hyaluronic Acid		Tattoo Removal	
PRP Hair Restoration		Skin Brightening	
PRP with Microneedling		Skin Rejuvenation	
RF Microneedling		Leg Veins	
Vaginal Rejuvenation		Skin Care Protocol	
3-Step Peel		Other	

Medical History Form

Do you have or have you ever had any of the following conditions?

Yes	No	Medical History	Please Specify
		Seizures and/or Epilepsy	
		Diabetes	
		Numbness in an area	
		Autoimmune Disorder	
		Sarcoidosis	
		Lupus	
		Scleroderma	
		Skin Disorders	
		Vitiligo	
		Keloid/Hypertrophic Scarring	
		Present Scarring	
		Herpes Virus/Cold Sores	
		Polycystic Ovarian Syndrome	
		Blood Clots/Phlebitus/Bleeding Disorder	
		Lymphedemia	
		Varicose Veins	
		Pregnancy/Actively trying to get pregnant	
		Cancer and/or Precancerous lesions	

Yes	No	Medical History	Please Specify
		Pacemakers/Internal Pacing Devices	
		Internal Metal Devices (rods, plates, screws)	
		Hip Replacement	
		Lymph Node Removal	
		Hernias	
		Past Surgeries	
Yes	**No**	**Medical Clearance Letter Required**	
		HIV/AIDS	
		Multiple Sclerosis	
		Chemotherary/Radiation treatment	
Yes	**No**	**Medication History**	
		Current Medications	
		Over-the-Counter Medications	
		Herbal Supplements	
		Retin-A or Generics	
		Blood Thinners (Coumadin, Aspirin)	
		Acne Medication	
		Oral Contraceptives	
		Accutane	Date Completed:
		Antibiotics	Date Completed
		Food Allergies	
		Medication Allergies	
		Latex Allergies	

Yes	No	Other	
		Permanent Make-Up	
		Tattoos	
		Recent Cosmetic Procedures	Date Completed:
		Botox/Restylane/Dermal Fillers	Date Completed:

I have answered all the questions truthfully and to the best of my knowledge.

Patient Name:_____

Patient Signature:_____

Date:_____