THE SKINCARE CENTER & SPA AT Tamarac

Confidential Client Information and Health History

Full Name _____ Date of Birth_____/_____/_____

Address: _____ City: _____State: _____ Zip:_____

Phone:_____ E-Mail:_____ Best form of contact:_____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____Relationship: _____

How did you hear about us? _____Referred by: _____

Please circle any of the conditions below that currently affect you or that you have experienced in the last two years:

MUSCULOSKELETAL
Fibromyalgia
Spasms/cramps
Sprains/strains
Osteoporosis
Osteoarthritis/rheumatoid arthritis
Sciatica
Thoracic outlet syndrome
Tendonitis
Torticollis
Whiplash syndrome
Carpal tunnel syndrome
Arm/ Shoulder pain
Low/ Mid back pain
Hip Pain
Headache
Leg pain

CIRCULATORY
Anemia
Hemophilia
Hypertension
Low blood pressure
Varicose veins
Heart condition
Bleeding abnormalities

OTHER
Insomnia
Anxiety/panic attacks
PMS
Grief process
Cancer *if YES please explain
_____
Chronic fatigue
HIV/AIDS

NERVOUS SYSTEM
Multiple sclerosis
Neuritis
Spinal cord injury
Stroke
Trigeminal neuralgia
Seizure disorders/epilepsy

SKIN
Infections/rash
Acne
Dermatitis/ Eczema
Psoriasis
Open Wound/ Sores
Athletes Foot
Plantar Warts
MRSA
Allergies to anything:_____

Are you currently under the care of a physician? _____ Physician's Name: _____

Are you currently taking any blood thinners or any prescribed acne medication, if so what?_____

Are you pregnant or nursing? _____ Weeks? _____ Are you taking birth control in any form?_____

My signature below constitutes my acknowledgement that I am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf), and further, that I (or my parent or legal guardian); Have read and understand the Information provided in this form; Have had my procedure adequately explained to me by my clinician; Have had the opportunity to ask Questions, and all of my questions have been answered to my satisfaction; Have received all of the information I desire concerning my Procedure; Consent to photographs of the treatment area; Consent to students in the procedure room for instructional purposes; Understand all post-treatment recommendations and agree to adhere to them; freely assume any risks of complications or injury from Known or unknown causes associated with, relating to, or otherwise arising out of this procedure; have the right to consent to or refuse Any proposed procedure at any time prior to its performance; I must notify the clinician if my medical history changes prior to service. With my signature I acknowledge that I have read and understand I am personally responsible for any and all charges for services I receive, and/or services that I authorize for any children for which I am a legal guardian. I further understand missed or cancelled appointments (medical emergencies excluded) without 24 hour notice is subject to payment in full for the missed session or deduction of one treatment from my package.

The above information is accurate and true to the best of my knowledge. I understand that Massage Therapists/Estheticians do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy or esthetic work is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session or a deduction from packaged purchased.

Signature: _____ Date: _____

Revised 10/2015