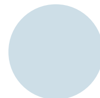
Client Health History: Body Contouring, Cellulite Reduction, and/or Skin Tightening Health History Intake



Name: ____Date of Birth: __________________

Address:___________________________City:____________________State:_______Zip: _______

Home/Cell Phone:____________________________Work: ________________________________

Email:_____________________________________ Preferred Contact: Cell___ Work ___ Emai ____

Emergency contact name: ______________________________ Phone ______________________

Relationship to you: ____

SKIN TYPE: Review the skin types below, using the Fitzpatrick Scale, and check the one that best describes your skin. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):

❏ I. Very fair skin; blonde or red hair; light-colored eyes; freckles common

❏ II. Fair skinned; light hair, light eyes

❏ III. Very common skin type; fair; eye and hair color vary

❏ IV. Mediterranean Caucasian skin; medium to heavy pigmentation

❏ V. Mideastern skin; rarely sun sensitive

❏ VI. Black skin; rarely sun sensitive

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ❏ Yes ❏ No

Areas of concern. Check all that apply:

____ Abdomen ____ Upper Legs “Saddle Bags” ____ Lower Legs (Hamstring Area) ____ Inner Thigh

____ Arms (tricep side) ____ Back ____ Buttocks ____ Calf ____ Flanks “Love Handles” ____ Other

Cosmetic History

Have you used Accutane in the past year? Yes____ No____

Are you using any topical creams, lotions, or oral antibiotics for acne, skin cancer, antiaging or hyperpigmentation? Please List; ____

____

Health History

Have you consumed drugs or alcohol in the last 24 hours? Yes___ No___

Do you exercise? Yes___ No ____ How often? ___________ What type? __________________

Have you had any other cosmetic surgeries/procedures? Yes ___ No___ If yes, when? ____________

What body area(s)?____

Have you had chemotherapy in the past 6 months? Yes___ No_____

Do you have moles/skin growths in the area to be treated? Yes___ No___

Do you have any allergies to medications, food, latex, topical products, and/or other substances? _______

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Continued ⇨

Do you have any of the following conditions?

___ Epilepsy ____Pregnancy and/or breastfeeding ____Autoimmune disease ____Herpes Simplex ____Diabetes ____Dental implants, crowns, metal fillings ____Pacemaker or internal defibrillator, implanted neuro stimulators, or other internal electric device ___Metal implants or other implants in the treatment area, i.e. IUD, screws, plates ___Varicose veins ___ History of skin disorders

Do you have a history of Erythema Ab Igne (EAI), which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? Yes ___ No ___

Do you have any other health condition not mentioned here? Yes___ No___ If yes, please list ________________

____

Have you undergone any recent surgery? Yes___ No___ If yes, please explain ______________________________

____

Please list all vitamins and supplements including herbal remedies you take regularly ________________________

____

Please list all current medications including aspirin, ibuprofen, blood thinners, etc. you take regularly __________

____

Is there anything else you would like us to know? ____

____

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 esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures.

Client Name (Printed) ____

Client Name (Signature) ____ Date: _________

Esthetician/Technician: ____ Date: _________