Health Information Questionnaire

First Name: _____ Last Name: _____

Address:_____ City/State/Zip Code: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email:_____ Date of Birth: _____

May we contact you via (Please check those that you approve):

__ email __home phone __mobile phone __postal mailings

How did you hear about Bare Body Shop? _____

Current Medications (include herbal supplements, vitamins, etc.):_____

_____

Allergies:_____

Have you ever been treated for the following conditions? *(If yes, please use a check mark to inidicate.)*

Today's Date: _____

_____AIDS
_____Anemia
_____Arthritis
_____Auto immune deficiency
_____Asthma
_____Chemotherapy
_____Diabetes
_____Dizziness
_____Epilepsy
_____Fainting
_____Heart Disease
_____Hepatitis
_____Cancer
_____Lupus
_____Melanoma
_____Mental Disorder
_____Respiratory Disorder
_____Skin Conditions
_____Sinus Problems
_____Stroke
_____Thyroid Problems
_____Liver Disease
_____Infection (active)
_____Cold Sores
_____High Blood Pressure
_____Fibromyalgia
_____Photosensitivity
_____Hormonal Disorders
_____Multiple Sclerosis
_____Other (Please Specify below)
_____
_____
_____
_____

Female Clients Only:

Are you currently pregnant or breastfeeding? Yes No

Previous Cosmetic Facial Treatments:

Chemical Peel Yes No Date_____

Botox Yes No Date_____

Fillers Yes No Date_____

Microdermabrasion Yes No Date_____

Facial Surgery Yes No Date_____

Facial Lasers Yes No Date_____

Accutane Yes No Date_____

Retin A/Renova Yes No Date_____

Permanent Makeup Yes No Date_____

Areas of Concern:

_____wrinkles

_____sun damage

_____age spots

_____dry/oily skin

_____loose skin

_____skin texture

_____acne scarring

_____unwanted hair

Areas of Interest:

_____Botox _____Fillers _____IPL Tx _____Laser Hair Removal _____ Laser Skin Tightening

_____Laser Tattoo Removal ____Microdermabrasion _____Pixel Laser Tx ____Skin Care

Emergency Contact:

Name: _____ Phone: _____

Relationship to this person: _____

I have recorded my health information to the best of my knowledge. I acknowledge that if there is any change in my medical condition, medication changes, or any other pertinent health concerns I will notify a provider prior to receiving services.

Client Signature:_____ Date: _____

For clients under the age of 19 years old:

Parent/Guardian Signature: _____Date:_____

Signature of BBS Clinician: _____ Date: _____