mahogany spa salon wellness

Please take a moment to carefully read/fill-out the following form and sign where indicated. If you have a specific medical condition or specific symptoms, facials and/or tinting may be contraindicated.

Name: _____

Address: _____

Phone _____ Emergency Contact:_____

Have you been under the care of a physician, dermatologist or other medical professional within the past year? ❍ Yes ❍ No explain:

_____

2) Any recent surgery, including plastic surgery? ❍ Yes ❍ No explain:

_____

3) Any skin cancer? ❍ Yes ❍ No explain:

_____

4) Have you had any piercings, tattoos, or permanent cosmetics? ❍ Yes ❍ No If yes, where on your person?

_____

5) Have you ever had a body spa treatment before? ❍ Yes ❍ No when:

_____

6) Have you had any of these health conditions in the past or present? (Please check all that apply) ❑ Headaches (chronic) ❑ Hormone imbalance ❑ Hepatitis ❑ Systemic disease ❑ Herpes ❑ High blood pressure ❑ Frequent cold sores ❑ Spinal injury ❑ Immune disorders ❑ Thyroid condition ❑ HIV/AIDS ❑ Hysterectomy ❑ Lupus ❑ Diabetes ❑ Cancer ❑ Metal pins or plates ❑ Heart problem ❑ Phlebitis, blood clots, poor circulation ❑ Varicose veins ❑ Blood clotting abnormalities ❑ Arthritis ❑ Psychological treatment ❑ Asthma ❑ Skin diseases/skin lesions ❑ Eczema ❑ Fever blisters! ! ❑ Epilepsy ❑ Any active infection ❑ Seizure disorder ❑ Keloid scarring ❑ Insomnia

7) Do you smoke? ❍ Yes ❍ No 8) Do you follow a restricted diet? ❍ Yes ❍ No specify:

_____

9) Do you follow a regular exercise program? ❍ Yes ❍ No 10) What is your stress level? High ❍ Medium ❍ Low ❍

(Please turn over) 11) List any medications you take regularly: _____

List any Over-the-Counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

_____

12) Do you use Retin-A, Renova, Glycolic Acid, AHA, Salicylic Acid, Retinol/ Vitamin-A derivative products? ❍ Yes ❍ No describe:_____

13) Have you used any of these products in the last 3 months? ❍ Yes ❍ No

14) Have you used an acne medication? ❍ Yes ❍ No, when? _____

Which drug?_____ 15) Do you form thick or raised scars from cuts or burns? ❍ Yes ❍ No 16)

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❍ Yes ❍ No, describe: _____

17) List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

18) Do you experience any problems sleeping? ❍ Yes ❍ No 19) How many hours do you typically sleep each night? _____ 20) Do you wear contact lenses? ❍ Yes ❍

No 21) Have you been exposed to the sun or used a tanning bed in the last 48 hours? ❍ Yes ❍ No

22) How frequently are you exposed to the sun or use a tanning bed? ❍ Infrequently ❍ Frequently

23) Do you have any metal implants or wear a pacemaker? ❍ Yes ❍ No

24) Have you ever experienced claustrophobia? ❍ Yes ❍ No 25) Do you suffer from sinus problems? ❍ Yes ❍ No

26) Have you ever had an adverse reaction after using any skin care product? _____

27) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs If yes, please explain: _____

28) Are you pregnant? ❍ Yes ❍ No 29) Are you lactating? ❍ Yes ❍ No 30) Any menopause challenges? ❍ Yes ❍ No specify: _____

All Clients 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 the skin from treatments received. I am aware that it is my responsibility to inform the Mahogany Salon and Spa skin care professional of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Mahogany Salon and Spa and/or the skin care professional from liability and assume full responsibility thereof.

Notes:

Client Signature: _____Date:_____

Client Name: _____

Esthetician Name _____ Date: _____