

Sweet Expressions MediSpa

Client History Form

Name: _____ Date: _____

Address: _____ City: _____

D.O.B. ____/____/____ Phone (Home) _____ Mobile: _____

Email Address: _____ Occupation: _____

How did you hear about me? _____ Referred by: _____

What is your main concern with your skin? _____

What skin products do you currently use: _____

Would you like to be on the emailing list to receive coupons and specials? Yes _____ No _____

Please mark (x) on all conditions that apply to you and specify.

Claustrophobia		High or Low Blood Pressure	
Anxiety/Depression		Epilepsy	
Diabetes		Dental implants	
Infectious Disease (HIV/AIDS/Hepatitis etc.)		Metal Implants	
Autoimmune disorders (Crohn's)		Heart Disease / Circulatory Disorder	
Headaches		Contact Lenses	
Muscle, joint pain / problems		Acne	
Asthma or lung conditions		Psoriasis / Rosacea / Eczema	
Skin sensitivities / easy bruising		Haemophilia	
Abdominal or digestive problems		Pregnant or trying / Lactating	
Herpes (genital or oral)		Hormone Imbalance	
Pace Maker		Irregular Menstruation	
Implants (breast or other)		Accutane / Isotretinoin	
Thyroid Condition		Collagen / Botox / Fillers – when ?	
Permanent Makeup / Tattoo		Anticoagulants	
Retinoids / Glycolic (Currently)		Cancer	

Allergies (latex, foods, aspirin, other): _____

Current Medications: _____

Recent Surgeries: _____

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

Witness Signature

Client Signature

Date