History and Health Questionnaire

Client Information

First Name: ___________________ Last Name: ___________________ Date of Birth: _____/_____/_____

Address: ______________ City: ______________ State: _____ Zip: _________

Home Phone: ______________ Cell: ______________ Email: ___________________

Emergency Contact: ___________________ Phone: ______________

How did you hear about us? ______________________________________

How do you prefer we confirm appointments? ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email

Please check all treatments that interest you:
☐Facials ☐Chemical Peels ☐Massage ☐Microdermabrasion ☐Botox® ☐Dermal Fillers
☐Sclerotherapy ☐Laser Hair Removal ☐Laser Skin Rejuvenation ☐Vein Therapy

General Medical Information

Family Physician: ________________________ Phone: ___________________

Dermatologist: ________________________ Phone: ________________________

List all allergies including cosmetics, foods, drugs, fragrance, etc.:
____
____
____

List all medications, supplements, vitamins, diuretics, etc., you are currently taking or have taken in the last 3 months:
____
____

Are you presently under a physician's care for any current skin condition or other problem?☐ Yes ☐ No
(If yes, explain:____)

Have you undergone surgery, cosmetic or otherwise, in the last year? ☐Yes ☐No
(If yes, what type of surgery and how long ago?____)

Do you smoke? ☐Yes ☐No (If yes, how much?__________)

Do you live with a smoker ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No (If yes, how often?__________)

Are you, or might you be pregnant? ☐Yes ☐No (If yes, how far along?__________)

Are you lactating? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No (If yes, what kind?__________)

Are you taking hormone replacement? Yes ☐No (If yes, what kind?____________________)

Do you wear contact lenses? ☐Yes ☐No

Rate your stress level on a scale of 1 to 5 (1= low stress, 5 = high stress).

Do you exercise? ☐Yes ☐No (If yes, how often?__________)

How many 8 oz glasses of water do you consume each day? _____

Please check (√) if you are affected by or have any of the following:

☐ Asthma
☐ Hepatitis
☐ Metal Bone, pins, or plates
☐ Edema
☐ Psoriasis
☐ Herpes
☐ Pacemaker
☐ Digestive Problems
☐ Eczema
☐ High Blood Pressure
☐ Psychological Problems
☐ Tuberculosis
☐ Epilepsy
☐ Hysterectomy
☐ Rosacea
☐ Anemia
☐ Fever Blisters
☐ Immune Disorders
☐ Skin Diseases
☐ Muscle Spasms
☐ Chronic Headaches
☐ Lupus
☐ Urinary or Kidney Problems
☐ Painful/Swollen Joints
☐ Diabetes
☐ Cancer (Skin or Other)
☐ Depression/Anxiety
☐ Herniated Disc
☐ Arthritis
☐ Heart Disease/Problem
☐ Blood clots/Phlebitis
☐ Osteoporosis

Please explain above problems or list any significant others:
____
____

Skincare Information

Please check (√) if you have used any of the following prescription skincare products in the last three months:

☐ Differin ☐ Renova ☐ Retin-A ☐ Accutane ☐ Azelex ☐Tazorac

Please explain how frequently you use the above products and list any other prescriptions taken topically or orally:
____
____
____

Do you sun bathe or use tanning beds? ☐Yes ☐No

Do you use sunscreen? Yes ☐No

Self-tanners? Yes ☐No

Do you sunburn easily? ☐Yes ☐No

Do you have a tendency to redness or flushing of the skin? Yes ☐No

Please check (√) what you feel best describes your skin type (check all that apply):
☐Normal
☐ Dry/Dehydrated
☐ Oily
☐ Combination
☐ Acne Prone
☐ Sensitive

What skincare products are you currently using?___________________________________

Have you had any chemical peels, microdermabrasion, or any resurfacing treatments in the last month?
☐Yes ☐No (If yes, which treatment and when?______________________________)

Massage Information

Do you suffer frequently from stress? ☐Yes ☐No

Have you had any accidents or injuries in the last two years? ☐Yes ☐No
(If yes, explain.____)

Do you have tension or soreness in a specific area? ☐Yes ☐No
(If yes, where? ____)

Do you suffer from back pain? ☐Yes ☐No

Do you suffer from neck pain? ☐Yes ☐No

Do you have numbness or stabbing pains anywhere? ☐Yes ☐No
(If yes, where?____)

Are you sensitive to touch or pressure in a particular area? ☐Yes ☐No
(If yes, where? ____)

What type of massage pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Reason for Visit

What is the main reason for your visit today?

____

What special areas of concern do you currently have?

____

Client Acknowledgment and Agreement

I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.

I hereby release and discharge Envy, A Medical Day Spa and its employees and agents from any and all claims that I have or may have in the future in connection with my treatment relating to any and all procedures performed by them, regardless of the results.

I hereby authorize and consent to having photographs taken of me. I understand that they may be used as an aid for treatment purposes (including without limitation, documenting the progress of my treatment) and that any photographs taken will remain the property of Envy, A Medical Day Spa. I further understand that using my photographs for any other purpose will require my signature on a different consent form and that my identity in those instances will be kept strictly confidential.

I hereby understand and acknowledge that Dr. Wusterhausen is a local physician with separate private practice, is the owner and Medical Director of Envy, A Medical Day Spa. In the event that I am a patient with this physician through his separate private practice, I understand and acknowledge that I am free to seek medical spa services elsewhere if I am not comfortable with my physician’s business interest in Envy, A Medical Day Spa.

I hereby assume full responsibility for the payment of any and all services rendered by Envy, A Medical Day Spa and will pay the full amount at the time of service, unless Envy, A Medical Day Spa customarily bills insurance for a particular service. If Envy, A Medical Day Spa bills my insurance for a particular service, then I authorize my insurance to pay Envy, A Medical Day Spa, directly for such service pursuant to the benefit terms of my insurance. I acknowledge and agree that I am ultimately responsible for any and all amounts that are not paid by my insurance. Furthermore, I acknowledge and agree that I am responsible for any collection agency costs, court costs, or attorneys’ fees incurred by Envy, A Medical Day Spa in collecting any outstanding balance for services rendered to me.

I hereby understand and acknowledge that Envy, A Medical Day Spa is a facility that is supervised by Medical Directors who are NOT always on site during procedures.

Client Signature: ___________________________________

Date: _______________