



CLIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Birthdate: _____
Phone: Main: _____ Message: _____
Email: _____
Employer: _____
Occupation: _____
Emergency: _____
How did you hear about us? _____

Please answer the following questions:

	Yes	No
1. Do you have ANY current or chronic medical illnesses? Please list: _____	_____	_____
2. Are you currently under a doctor's care? Please list: _____	_____	_____
3. Are you currently taking ANY medication, herbal supplements or use topical cream and/or ointment(s) on a regular basis? Please list: _____	_____	_____
4. Do you have allergies to ANY food or substances? Please list: _____	_____	_____
5. Are your menstrual periods regular?	_____	_____
6. Are you or could you be pregnant?	_____	_____
7. Do you have ANY history of herpes simplex (e.g. cold sores, fever blisters, or genital)?	_____	_____
8. Do you have a history of keloid scarring?	_____	_____
9. Have you taken Accutane or anticoagulants in the last 6 months?	_____	_____
10. Do you have ANY permanent make-up, implants or tattoos? Please list: _____	_____	_____
11. Have you been in the sun, tanning bed or used sunless tanning cream within the last 4 weeks?	_____	_____
12. Which area(s) would you like treated? _____ _____		

Signature: _____ Date: _____