

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: _____