Spa Consent & Release Form

Name: _____
First Middle Initial Last

Address: _____
Street City State Zip

Phone: (c)_____ (h)_____ (o)_____
❒ opt-in for text messaging

DOB: _____/_____/_____ How did you hear about us:_____

Email: _____
❒ I allow my e-mail to be used for marketing purposes. Spa 360 does not sell our patient's information.

Emergency Notification:_____
Name/Relationship Phone#

Patient Responsibility

If you are unable to keep your scheduled appointment, we require a 24 hour cancellation notice or a $25 late cancellation/no show fee will be charged to your account. Please note too that all give certificate and pre-paid services expire one year from the date of purchase. Any unused credit balances after one year will be lost. By signing below, you acknowledge reading and agreeing to the above terms.

_____ _____/_____/_____
Signature of client (or responsible party if client is a minor) Date

General

Please list any cosmetic procedures your have had in the last 12 months (including peels, laser resurfacing , facial surgery, Botox, Juvederm, other fillers, etc.)

What skin care products are you currently using:

- Cleanser:
- Exfoliant:
- Moisturizer:
- Sunscreen:
- Other (Serums, Antioxidant, etc):

What is your primary skin care challenge?

Blotchy/Hyperpigmentation Fine Lines/Wrinkles Sun Damage Sensitive Acne

Have you ever had fever blisters or cold sores?	Y	N
Are you currently taking Accutane or have you completed a course of Accutane in the past 6 months?	Y	N
Are you currently using Retin-A?	Y	N

What is your ethnic background (German, French, etc.)

If you go out in the sun without sunscreen, how often will you burn?

Always Most of the Time Sometimes Rarely Burn Very Rarely I Never Burn

Health History

Have you been under the care of a physician, dermatologist or other medical professional within the past year?	Y	N
If yes, please explain		
Have you had any recent broken bones, illnesses, injuries, or surgeries (including cosmetic surgery)?	Y	N
If yes, please explain		
Have you had any body piercings, tattoos, or permanent cosmetics?	Y	N
If yes, please explain		
Do you smoke?	Y	N
Do you exercise regularly?	Y	N
Do you wear contact lenses?	Y	N
Do you have any metal implants or pacemaker?	Y	N
How much water do you consume daily?		
Please rate your level of stress on a scale of 1 to 4 (1=low stress, 4=high stress)		
Are you pregnant, trying to become pregnant, or breast feeding?	Y	N
If yes, please specify, including complications	Y	N
Do you have a family history of skin cancer?	Y	N
Do you experience keloid or raised scarring?	Y	N
Do you have any known allergies or skin sensitivities?	Y	N
If yes, please list including aspirin and plant allergies.		
Is there any other medical condition you would like to tell us about?		

What medications are you currently taking? (including over the counter vitamins, herbs, and supplements)

What improvements would you like to see in your skin?

I understand the information I have provided above is true and correct. I also understand that all information stated is strictly confidential and will not be shared outside of this facility due to HIPPA regulations.

Client Signature Date

Skin Care Specialist Date

Revised May 1, 2014