

Date / /

Facial & Waxing Confidential Health Information				
First Name	MI	Last Name		Email (please send me a newsletter <input type="checkbox"/> Yes!)
Address	City	State	Zip	Occupation
Home Phone ( ) -	Cell/Work Phone ( ) -	Emergency Contact ( ) -		Date of Birth / /
How did you hear about us? <input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Facebook <input type="checkbox"/> I'm a Valley Member <input type="checkbox"/> Referral/Other				
Are there any physical or medical conditions that the Skin Care Professional should be aware of prior to treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes (please explain)				

**History (please check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Pregnant or lactating                | <input type="checkbox"/> Seeing a dermatologist?   |
| <input type="checkbox"/> Hypo/hyper thyroid                   | <input type="checkbox"/> Have you had recent Botox, Microdermabrasion or peeling treatments?               |
| <input type="checkbox"/> Heart disease/pacemaker              | <input type="checkbox"/> Have you had permanent makeup where you wish to wax in the past 2 weeks?          |
| <input type="checkbox"/> Diabetes, Epilepsy, Hemophilia       | <input type="checkbox"/> Have you had intense light treatment in the past 7 days?                          |
| <input type="checkbox"/> High/low blood pressure              | <input type="checkbox"/> Have you used a tanning bed in the past 24 hours?                                 |
| <input type="checkbox"/> Cancer, HIV, Immune Disorder, Herpes | <input type="checkbox"/> Have you had sun spots removed since the last treatment?                          |
| <input type="checkbox"/> Open wounds/lesions or infections    | <input type="checkbox"/> Have you had laser, collagen injections or plastic surgery since your last visit? |
| <input type="checkbox"/> Do you smoke?                        | <input type="checkbox"/> Are you due to start your menstrual cycle in the next 2 days?                     |
| <input type="checkbox"/> Do you wear contacts?                | <input type="checkbox"/> Are you currently involved in a fitness program?                                  |

**Medication History (please check any that you have taken or used in the past 4 months)**

- |   |  |  |                                     |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Retin-A and Renova | <input type="checkbox"/> Topical Antibiotics | <input type="checkbox"/> Accutane (within the last year) | <input type="checkbox"/> Cumacin    |
| <input type="checkbox"/> Metro Gel          | <input type="checkbox"/> Deffarin Gel        | <input type="checkbox"/> Metro Cream                     | <input type="checkbox"/> Prednisone |

What is your daily skin care routine? \_\_\_\_\_

What products do you use? \_\_\_\_\_

Have you ever had a topical skin reaction? If so, what did you react to? \_\_\_\_\_

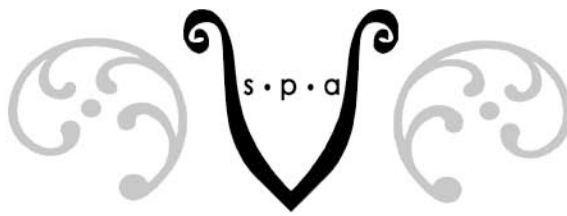
Do you have any known allergies or sensitivities If so, indicate which substances affect you (specifically iodine or seaweed)

**Self Skin Evaluation (Facials Only)**

Overall, do you describe your skin as (please check all that apply)

- |           |                                     |                                   |   |  |
|-----------|-------------------------------------|-----------------------------------|---|--|
| Oily      | <input type="checkbox"/> All over   | <input type="checkbox"/> T-zone   | <input type="checkbox"/> Blackheads     | <input type="checkbox"/> Prone to breakouts, frequency: _____          |
| Dry       | <input type="checkbox"/> All over   | <input type="checkbox"/> Patches  | <input type="checkbox"/> Rough/flaky    | <input type="checkbox"/> Itchy/tight                                   |
| Sensitive | <input type="checkbox"/> Allergic   | <input type="checkbox"/> Blotchy  | <input type="checkbox"/> Easily reddens | <input type="checkbox"/> Easily irritated, cause of irritation: _____  |
| Mature    | <input type="checkbox"/> Fine lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Crows feet     | <input type="checkbox"/> Loose skin <input type="checkbox"/> Age spots |

If you could change two characteristics about your skin, what would they be? \_\_\_\_\_



**PLEASE INITIAL AFTER EACH POLICY TO SAY THAT YOU READ AND UNDERSTAND THE POLICY**

**I understand that giving 24 hours notice or more for cancellations or rescheduling will not result in any charge for that appointment.**

\_\_\_\_\_  
**INITIAL**

***Any missed/cancelled appointment(s) without 24 hours notice will result in charge of the full amount of the service and will be charged to the credit card I have provided on file (non-members), gift card, or my Valley membership (members only)***

\_\_\_\_\_  
**INITIAL**

Any returned check will result in a charge of \$25.00. I will then only be able to pay by cash or credit card for payment.

\_\_\_\_\_  
**INITIAL**

I understand that estheticians do not diagnose illness, disease, or other medical, physical, or emotional disorders or prescribe medical treatment or pharmaceuticals. It has been made clear to me that treatment is not a substitute for medical examination or diagnosis and that I am responsible for consulting a qualified physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the esthetician updated on my physical health. I also affirm that I am at least 18 years of age, or have parental consent to receive my treatment today (if under 18, parent signature must be present)

Also, since spa services have been reserved especially for me, I will notify the V Spa 24 hours in advance to change/cancel appointments without penalty.

Signature	Date / /
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