Forest of Youth
Holistic Spa

Client Health History and Consent Form

Name_____ Date_____

Address_____

Phone (Home/Cell)_____ Phone (Business)_____

Date of Birth_____ Email_____

How did you hear about us?_____

Emergency Contact

Name_____ Relationship_____

Phone (Home/Cell)_____ Phone (Business)_____

Health History (Circle all that apply)

Heart Problems	Hormonal Problems	Blood Pressure (High / Low)
Skin Cancer	Diabetes	Thyroid (Hyper / Hypo)
Organ Transplants	Pacemaker/Defibrillator	Lupus
Multiple Sclerosis	Fibromyalgia	Adrenal Insufficiency
Arthritis	Blood Clots	Bruise Easily
Cancer	Chronic Pain	Hepatitis (A, B, C)
Stroke	Migraines	Scoliosis
Seizures	Chronic Fatigue	AIDS

Please provide details or if there is anything else you'd like to share_____

_____

_____

Allergies (Seasonal, Herbs, Food, Chemical.. etc)_____

_____

Other Medical Conditions (explain)_____

_____

Do you have any of the following today? (Please circle)

Skin Rash	Cold/Flu	Open Cuts
Anything Contagious	Injuries/bruises	Severe Pain
Cold Sores/Fever Blisters	Allergies	Constipation/Diarrhea

Please give details_____

Are you Pregnant? Yes No

Recent Surgery? (Please explain)_____

Are you taking Birth Control Pills?	**Yes**	**No**
Are you or have you taken Accutane?	**Yes**	**No**
Are you using Retin-A?	**Yes**	**No**
Are you using ANY topical medications?	**Yes**	**No**
Are you using Alpha-Hydroxy Acids?	**Yes**	**No**
Are you taking Antibiotics?	**Yes**	**No**
Do you smoke?	**Yes**	**No**
Are you exposed to secondary smoke?	**Yes**	**No**
Do you wear fragrance?	**Yes**	**No**
Do you wear sunscreen?	**Yes**	**No**

Do you have any implants? (Pacemaker, pins in bones, etc. Please List)_____

_____

Are you taking any herbal remedies, supplements or Homeopathics? Yes No

Please list _____

_____

Are you currently under a lot of stress? Yes No

Do you exercise regularly? Yes No

What kind of exercise and how frequently?_____

Do you meditate? Yes No

What is your current skin care regimen?

Cleansing_____ Toner_____

Serum_____ Moisturizer_____

Exfoliant_____ Masks_____

Eye Cream_____ Night Cream_____

SPF_____ Makeup_____

What improvements would you like to see on your face?_____

_____

Are you willing to make lifestyle changes to achieve results? Yes No

Have you ever received Relaxation Massage? Yes No

Have you ever received Reiki or Energy Healing? Yes No

Have you ever worked with Bach Flower Therapy? Yes No

Have you ever experienced Vibrational or Sound Healing? Yes No

Are you here to just relax and experience stress relief? Yes No

Any other goals or concerns you would like to address with me?_____

_____

_____

_____

Consent Form

Prior to receiving treatment, I have presented any condition that may impact the procedure, such as but not limited to: pregnancy, recent surgeries, allergies, frequent cold sores and fever blisters, use of oral and topical prescription medications.

I understand there may be some degree of discomfort such as tingling, pin-pricking, heat or tightness.

I understand there are no guarantees with regards to the result of this treatment due to many variables like: age, condition of skin, sun damage, smoking, environmental pollutants.. etc.

I understand that I may not actually peel and that the amount of peeling does not relate to the degree of improvement.

I understand this is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that to achieve maximum results, it may require several to many treatments.

I understand that although complications are rare, sometimes they may occur and that prompt treatment is necessary. In the event of complications, I will immediately contact the clinician who performed the treatment.

I agree to refrain from tanning in tanning beds or outdoors while I am undergoing treatment and during the 14 days prior to and following the end of the treatment. It is recommended that tanning be discontinued altogether.

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory.

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand that I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results.

I hereby agree to all of the above and agree to have this treatments and following treatments performed on me. I further agree to follow all post-peel care instructions.

Print Name: _____

Signature: _____ **Date:** _____