



ACUPUNCTURE & WELLNESS

Would you like to receive a copy of our newsletter containing helpful information about natural medicine and exclusive offers?

Y N

Skin Care Client Profile

Name: _____ Date: _____

Email Address: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Phone #: Home (_____) _____; Cell (_____) _____

Emergency Contact Name and Phone: _____ Referred by: _____

What is your treatment goal today? (Please circle all that apply):

Toning/Tightening Skin Rejuvenation Pampering/Relaxing Symptomatic Relief (headache, jaw, neck pain)

Please indicate your skin type: (Circle all that apply):

Oily Dry Blemished Sensitive Normal Combination

1. Please list any allergies to topical products, medications, foods or any other substances: _____

2. Current medications (topical & oral): _____

3. Are you under a doctor's care for any acute or chronic condition? (Examples include infectious condition, metal implants/pins, skin conditions, epilepsy, pacemaker/defibrillator or circulation disorders): _____

4. Are you: A smoker: Y N Pregnant: Y N Wearing contact lenses? (Please remove before treatment.) Y N

5. Any surgeries or major dental work within the last 6 months? Y N If yes, please explain: _____

6. In the last six months, have you had any: dermal injections/fillers, facial cosmetic surgery or waxing, chemical peels or laser treatments? Y N If yes, please explain: _____

8. Have you ever had (please circle any that apply): Acne Eczema Psoriasis Herpes Simplex

9. (a) Are you using any products that contain Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A? Y N

(b) Have you used any of these products in the past 3 months? Y N If yes, describe: _____

10. What type of skin care products do you use? _____

11: Would you be interested in learning about natural products that meet your skin care goals? Y N

Client Consent: I have read and understood this questionnaire and completed it truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the esthetician/practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the provider in giving better service and is completely confidential. The services I receive here are voluntary, and I release Heritage Acupuncture & Wellness LLC and this provider from any liability resulting from this or any services received at Heritage or from any products or tools used during treatments or purchased from Heritage Acupuncture LLC and assume full responsibility thereof. I also understand that it is my responsibility to cancel or reschedule appointments at least 24 hours beforehand; otherwise, a cancellation fee of 50 % of the scheduled service may result.

Client Signature: _____ Date: _____