Rilassare Esthetics

New Client Health History

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, enabling me to accurately analyze and access your unique skin care needs.

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____ Cell/Home (circle)

How may I contact you (check all that apply) ☐ E-mail ☐ Text Message* ☐ Home

*I consent to receive marketing messages from Rilassare Esthetics regarding special offers and updates. 3 Msgs/Month. Reply STOP to cancel, HELP for help. Msg & data rates may apply. Terms: slkt.io/QD

Have you seen a Dermatologist in the past year? ☐ Yes ☐ No

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently taking any medications? ☐ Yes ☐ No List: _____

Please check all that apply:

- ☐ Hypertension
- ☐ Cold Sores
- ☐ Anemia
- ☐ Cancer
- ☐ Seizures
- ☐ Headaches
- ☐ Fainting
- ☐ Contacts
- ☐ Metal Plates/Implants/Pins
- ☐ Hernia
- ☐ Lupis
- ☐ Thyroid Disorder
- ☐ Eating Disorder
- ☐ Claustrophobia
- ☐ Asthma
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Stroke
- ☐ Hepatitis
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Keloid Scars
- ☐ Pacemaker
- ☐ Heart Condition
- ☐ Hysterectomy
- ☐ Eczema
- ☐ Psoriasis
- ☐ Autoimmune
- ☐ Polycystic Ovarian Syndrome
- ☐ Other _____
- ☐ None

Female Clients Only:

Are you on hormone replacement therapy? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are presently taking birth control pills? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you currently having skin treatments? ☐ Yes ☐ No

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Have you had any of the following?

- ☐ Skin Cancer
- ☐ Broken Capillaries
- ☐ Dermatitis Treatment Reactions
- ☐ Keloid Scarring
- ☐ Hyperpigmentation
- ☐ Acne
- ☐ Rosacea
- ☐ NA

Have you had any of the following within the last 14 days?

- ☐ Facial Cosmetic Surgery
- ☐ Chemical Exfoliation (peels)
- ☐ Botox, Fillers, or Injectables
- ☐ Extractions
- ☐ Microcurrent
- ☐ Permanent Makeup
- ☐ LED Light Therapy
- ☐ Waxing
- ☐ Photofacials
- ☐ Laser Hair Reduction
- ☐ Laser Resurfacing or CO^2
- ☐ Microdermabrasion
- ☐ Eyelash Extensions
- ☐ Dermaplaning

Please check if you have been prescribed any of the following medications:

- ☐ Benzyl Peroxide
- ☐ Isotretinoin (Accutane)
- ☐ Steriods/Cortisone Creams
- ☐ Tetracycline/Minocycline
- ☐ Retinoids (Retin-A, Renova, Differin, Tazorac)
- ☐ Hydroquinone (Lustra, Tri-Luma, EpiQuin Micro)
- ☐ Metronidazole (MetroGel, Flagyl)
- ☐ Ointments/medications to treat acne/skin condition _____

Have you ever had an allergic reaction to any of the following:

- ☐ Aspirin
- ☐ Nuts
- ☐ Shellfish
- ☐ Iodine
- ☐ Citrus
- ☐ Pollen
- ☐ Alpha Hydroxy Acids
- ☐ Fragrances
- ☐ Essentials Oils
- ☐ Other _____

Home Care:

Please list the skin care products you are currently using at home: _____

_____

_____

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Do you tan in a tanning booth? ☐ Yes ☐ No

When exposed to the sun do you (please check ONE):

- ☐ Always burn, never tan
- ☐ Burn easily, tan poorly
- ☐ Burn first, tan okay
- ☐ Occasionally burn, tan easily
- ☐ Very rarely burn, tan very easily
- ☐ Never burn, always tan darkly

Please check areas of concern:

- ☐ Premature Aging
- ☐ Sun Damage
- ☐ Oil Control
- ☐ Fine Lines/Wrinkles
- ☐ Pore Size, Surface Condition or Texture
- ☐ Pigmentation: Redness/Discoloration
- ☐ Uneven Tone
- ☐ Acne and/or Blemish Control
- ☐ Dryness and Irritation
- ☐ Stress Reduction & Relaxation
- ☐ Other _____

I have read the following treatments and agree to any treatment or future treatments I may choose. I understand that I am willing to follow recommendations by my Esthetician for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including the importance of wearing SPF. I understand if I have any concerns, I will address these with my Esthetician. I have accurately read and answered any questions above, and that all the information provided by me is true and correct to the best of my knowledge, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I hereby release Rilassare Esthetics from any liability pertaining to treatments, understanding that results cannot be guaranteed due to individual skin types and conditions.

Cancellation Policy: 24 hour notice is required when cancelling or rescheduling an appointment.

No Shows: Anyone who forgets or consciously chooses to forgo their appointment will be considered a "No-Show" and will be charged $40 fee and online booking may be revoked.

Late Arrivals: If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, I will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for the "full" session. Out of respect and consideration to other clients, please plan accordingly and be on time.

Gift Certificates: Gift Certificates are non-refundable, non-returnable and must be presented at time of service. Expired or non-present gift certificates will not be honored. They are guaranteed for purchase dollar value as service prices may change without notice.

Prices: All prices and services are subject to change without notice. No Refunds, Credit only towards your next service

Signature: _____ Date: _____

Parent Signature: _____ Date: _____

(If under age of 18 years old)