



Client Information & Consent Form for Skincare services. This form must be completed and signed before receiving any skincare treatments.

Name _____ Tel. No (h) _____ (w) _____ (c) _____

Address _____ Apt _____ City _____ State _____ Zip _____

DOB ___/___/___ Occupation _____ Email _____

Emergency Contact Name _____ Phone No _____ Relationship to You _____

Referred by _____

General & Medical Information

Have you ever experienced a professional massage? Yes No How recently? _____

Have you ever received any treatments at Element Natural Healing Arts? Yes No

How recently? _____ Which service? _____

Do you have any of the following conditions? If checked () , please explain below as clearly as possible.

- | | | |
|---|--|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Allergies | <input type="checkbox"/> Contagious disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Wear contact lenses | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Facial plastic surgery | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cardiac or circulatory problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Very sensitive to touch or press | <input type="checkbox"/> Frequent headaches |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Joint swelling | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Numbness or stabbing pains?
Specify below | <input type="checkbox"/> Tension or soreness in a specific area?
Specify below | <input type="checkbox"/> High blood pressure?
If yes, taking medication for this? |
| <input type="checkbox"/> Surgery in the past five years?
Explain below | <input type="checkbox"/> Accident or any injuries in the past 2
years?
Explain below | <input type="checkbox"/> Other medical conditions not listed?
Explain below |

Comment _____

Within the last 6 months have you used or are you currently using Accutane or Retin-A? Yes No

Are you taking any medications (prescribed or over the counter)? If so, please give details.

Past surgeries? Please give details and dates.

I understand that the skincare treatment I receive is not a replacement for medical care and no diagnosis will be made. If I experience any pain or discomfort during the session, I will immediately inform the esthetician. I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile and understand that there shall be no liability on the esthetician's part should I fail to do so. I understand that by signing this form, I give my consent to receive the treatment discussed in this and all future sessions and agree that my presence at subsequent sessions shall be construed to be validation of this written consent.

Client Signature _____ Date _____