DATE_____ NC TEACHING SPA - HEALTH HISTORY

Client Information (Please Print)

As a Teaching Institution we are required to have you accurately complete this form

Client Name: **Gender: M / F / X**	**Date of Birth:**
Full Mailing Address:	**Occupation:**
Home: **Cell:** **Business:** **ext:**	
Email Address:	
I give permission to be contacted for appointment reminders and confirmations (circle) YES NO	
Would you like to be contacted via (circle) TEXT or EMAIL	
Emergency Contact Name: **Phone #:**	
Who referred you to our facility/How did you hear about us?	
What Spa services have you had in the past?	
Do you have any scent concerns?	

General Health History

This file will be kept strictly confidential. It is important to answer questions fully and adequately to ensure you will receive adapted treatments, taking into consideration the particulars of your individual health. Thank you for your assistance.

This health history will be reviewed with you by your Esthetician (if necessary). Periodically we will ask you to complete a new history to monitor any changes that may affect the nature of the treatments you are receiving. If any changes occur prior to the completion of a new health history, please be sure to inform the staff or your esthetician at NC Teaching Spa.

Please check if you experience the following conditions (Y- Yes**, N-** No**). Please give details where necessary.**

	Y	N	Details		Y	N	Details
Contact Lenses or Glasses	❑	❑		Known Allergies	❑	❑	
Do you have Latex Allergies?	❑	❑		Prone to Dizziness	❑	❑	
Asthma/Hayfever/ Seasonal Allergies	❑	❑		Do you have Gluten/Wheat Allergies (Celiac Disease)	❑	❑	
Hands and/or Feet Cold	❑	❑		Metal in the body?	❑	❑	
Varicose Veins	❑	❑		Inflammation or Swollen Joints	❑	❑	
Low Blood Pressure	❑	❑		Pain or Numbness	❑	❑	
High Blood Pressure	❑	❑		Circulation/Cardiovascular/Heart Conditions	❑	❑	
Nervousness/Anxiety	❑	❑		Epilepsy	❑	❑	
Excessive Perspiration	❑	❑		Edema or Swelling	❑	❑	
Prone to Sinus Infections	❑	❑		Dental Conditions or Apparatus	❑	❑	
Prone to Earaches	❑	❑		Stomach Disorders	❑	❑	
Prone to Sore Throats	❑	❑		Known Skin Conditions or Concerns	❑	❑	
Diabetes	❑	❑		Are you prone to Cold Sores	❑	❑	
Osteoarthritis/Rheumatoid Arthritis	❑	❑		Have you/are you using Retin A	❑	❑	
Osteoporosis	❑	❑		Have you/are you using Accutane	❑	❑	
Respiratory Conditions	❑	❑		Are you taking Antibiotics	❑	❑	
Cancer or history of Cancer	❑	❑		Digestive Disorders	❑	❑	

Recent appointment/treatment with Dermatologist/Plastic Surgeon (details):

When was your last complete physical examination?

Please circle if you do any of the following (Y- Yes**, N-** No**). Please give details where necessary.**

Do you Tan? **Y N** How often? Outdoor/Summer Time:	Indoor Tanning Bed:
Have you had a bad sunburn? **Y N** How long ago?	
Do you smoke? **Y N**	On average how many hours of sleep do you get each night?
Do you feel you get regular exercise? **Y N** Type:	

Diet

Do you follow any special diet or dietary restrictions?
Please check any that apply and provide details where necessary

Standard American Diet (SAD)	❑	Paleo	❑
Vegetarian	❑	Alkaline	❑
Vegan	❑	Mediterranean Diet	❑
Low Carb	❑	Intermittent Fasting	❑
Ketogenic	❑	Weight Watchers	❑

Food allergies/intolerances/restrictions?

Other

On Average indicate if the following are part of your weekly food diet and how much.
Circle *N -* *Never*, *R -* *Rarely*, *S -* *Sometimes*, *O-* *Often* **Provide details where necessary**

Juices	N	R	S	O
Pop	N	R	S	O
Coffee	N	R	S	O
Tea	N	R	S	O
Alcoholic Beverages	N	R	S	O

On average how may glasses of water do you drink per day?

Other Medical Conditions or Concerns (Please specify):

Medications [Creams/Pills] and/or conditions used for (Please include herbals/vitamins/essential oils):

Other:

Women Only (Y- Yes**, N-** No**)**

Are you:	Y	N	Are you:	Y	N	
Premenopausal	❑	❑	Pregnant or trying to become pregnant?	❑	❑	If Pregnant, how long?
Menopausal	❑	❑				
Post Menopausal	❑	❑	How long ago was your period?			

Acknowledgement

I, the undersigned, recognize the importance of the accuracy of the information provided to ensure the smooth running of the salon/spa treatments I will be receiving. Consequently, I confirm this information to be correct.

Client Signature:	Date:
Esthetician Name (Print):	Date:

Client Follow-up Appointment Review

2nd Esthetician Name (Print):	Date Reviewed:	Comments:	Client Initials:
3rd Esthetician Name (Print):	Date Reviewed:	Comments:	Client Initials:
4th Esthetician Name (Print):	Date Reviewed:	Comments:	Client Initials:
5th Esthetician Name (Print):	Date Reviewed:	Comments:	Client Initials: