

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 (MM/DD/YY): _____

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

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? N Y	How often? Outdoor/Summer Time:	Indoor Tanning Bed:
Have you had a bad sunburn? N Y	How long ago?	
Do you smoke? N Y	On average how many hours of sleep do you get each night?	
Do you feel you get regular exercise? N Y	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) <input type="checkbox"/>	Paleo <input type="checkbox"/>
Vegetarian <input type="checkbox"/>	Alkaline <input type="checkbox"/>
Vegan <input type="checkbox"/>	Mediterranean Diet <input type="checkbox"/>
Low Carb <input type="checkbox"/>	Intermittent Fasting <input type="checkbox"/>
Ketogenic <input type="checkbox"/>	Weight Watchers <input type="checkbox"/>
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 many 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	If Pregnant, how long?
Premenopausal	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant or trying to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Menopausal	<input type="checkbox"/>	<input type="checkbox"/>	How long ago was your period?			
Post Menopausal	<input type="checkbox"/>	<input type="checkbox"/>				

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: