Name:	
Date:	
DOB:	
Phone:	
Email:	
Service:	
Notes: `	

Z Medi Spa

CLIENT HEALTH HISTORY

Fill in this form to the best of your ability; please make notes on the back as this is for informational purposes. This form is merely a beginning of our information gathering process. When you make your appointment to meet with a Personal Image Consultant, bring this form (and the Condition Reviews) with you. as your concerns will be addressed in detail during your 30 minute consultation.

TODAY'S DATE_____ **REFERAL** _____

NAME/LAST_____**FIRST**_____**M**☐ **F**☐ **DOB (OPTIONAL)**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

PHONES/HOME _____ **WORK** _____**CELL** _____

EMAIL ADDRESS _____ **FAX NUMBER** _____

HEIGHT _____**FT**_____**IN** **WEIGHT** _____ **OCCUPATION**_____

☐ YES ☐ NO Are you currently taking any medications?_____
☐ YES ☐ NO Do you have allergies to any medications?_____
☐ YES ☐ NO Do you have any allergies?_____
☐ YES ☐ NO Have you ever suffered a severe allergic reaction, explain?_____
☐ YES ☐ NO Have you ever had an allergic reaction to local anesthesia, explain?_____
☐ YES ☐ NO Do you smoke? How many years? _____ How much_____/day?
☐ YES ☐ NO Have you ever smoked? How many years? _____ How much_____/day?
☐ YES ☐ NO Have you ever had surgery? List_____
☐ YES ☐ NO Have you ever had cosmetic surgery? List_____
☐ YES ☐ NO Do you have cardiovascular or heart disease?
☐ YES ☐ NO Do you have diabetes?
☐ YES ☐ NO Do you have epilepsy?
☐ YES ☐ NO Is there any incidence of cancer in your family?_____
☐ YES ☐ NO Do you have hepatitis?
☐ YES ☐ NO Do you have migraine headaches?
☐ YES ☐ NO Do you have asthma/hay fever?
☐ YES ☐ NO Do you have high/low blood pressure?_____
☐ YES ☐ NO Have you ever had herpes, cold sores, fever blisters, keloids, hives?_____
☐ YES ☐ NO Are you currently under a physician's care? Explain_____
☐ YES ☐ NO Do you have venereal disease, HIV, AIDS?_____
☐ YES ☐ NO Do you have thyroid or kidney problems?_____
☐ YES ☐ NO Do you have emphysema?
☐ YES ☐ NO Do you have incidents of fainting or dizzy spells?_____
☐ YES ☐ NO Do you have any drug addictions?
☐ YES ☐ NO Do you have anemia?
☐ YES ☐ NO Do you have arthritis?

QUESTIONS RELATING TO SKIN/SKIN CARE

☐ YES ☐ NO Is your family prone to vascular blemishes? Spider Veins_____ Varicose leg veins_____ cherry anginoma_____ broken facial capillaries_____ Upper body capillaries_____?
☐ YES ☐ NO Have you ever visited a dermatologist, plastic surgeon, cosmetic dentist, or other skin care therapist?_List_____

☐ YES ☐ NO Have you ever used Retin A or a similar product?_____
☐ YES ☐ NO Do you use skin products such as moisturizer, cleanser? Explain_____
☐ YES ☐ NO Do you suntan? Do you use sunscreen?_____
☐ YES ☐ NO Do you follow a diet and watch your caloric intake?
☐ YES ☐ NO Do you follow an exercise routine?

Is your skin: ☐ Dry ☐ Oily ☐ Normal ☐ Combination

Are you ☐ Fair ☐ Olive ☐ Asian ☐ Hispanic ☐ Native American ☐ African American

What are you concerns with your skin?_____

How much liquid do you drink /day?_____

What vitamins/minerals do you take regularly?_____

Comments_____

I have completed the Health History questionnaire. I am in good physical condition and mental state. I have no physical restrictions, conditions, disabilities or ailments that are not noted here. I am cleared by my health care professional to get treatment from the Z Medi Spa.

Signature_____

Printed Name _____

NOTES:

GENERAL INFORMED CONSENT

I _____, consent to, and authorize the staff of ZMediSpa to perform: laser (Hair Removal/IPL/Skin tightening/Resurfacing/Tattoo removal), skin (Peels/facials/ect.), injectables (Filler/Toxins/PRP) and Body Contorting (Vanquish).

1. The nature and purpose of the treatment(s), its possible benefits, and alternative treatments have been explained to me. Any questions I have regarding this treatment have been answered and explained to my satisfaction. _____(Initial)

2. I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these potential risks. _____(Initial)

3. Possible side effects include, but are not limited to, mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, post inflammatory hyper pigmentation, bumpy appearance, cold sores, or scarring. Most side effects are temporary and generally subside within 72 hours. _____(Initial)

4. If I am prone to Herpetic outbreaks (cold sores or fever blisters), I understand that I may need to take any oral anti-viral medicine. If necessary, the ZMediSpa staff will supply me with the appropriate prescription for this medicine. _____(Initial)

5. I acknowledge that no guarantee or assurance, expressed or implied, has been made by anyone regarding this treatment, or series of treatments, which I have herein requested and authorized. _____(Initial)

6. I realize that the procedure may not be successful and the result may not be as I fully desire. _____(Initial)

7. I give my consent to the administration of anesthetics. _____(Initial)

8. I agree to adhere to all safety precautions and home post-treatment skin care programs recommended by the ZMediSpa staff. _____(Initial)

9. I am over 18 years of age or I have parental consent (co-signed below) _____(Initial)

10. I will inform the ZMediSpa staff of any complications I may develop, as soon as they may occur. _____(Initial)

11. I am aware of the 24 hour cancelation policy and know that there is a $25 fee for all no shows and late cancelations. _____(Initial)

12. I am aware that ZMediSpa may need to take my photo. I authorize them to be used for in office use like charting _____(Initial) & marketing materials _____(Initial).

Name _____ Date _____
Client Signature_____
Parent or Guardian Signature (if client is a minor) _____
Witness _____

CREDIT CARD ON FILE POLICY

At Z Medi Spa we require keeping your credit or debit card on file for cancellation/ no-show fees of $25 for appointments missed or canceled within a 24 hour period.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer.

I authorize Z Medi Spa to charge the following credit or debit card:

Credit Card Number
_____Type:_____

Expiration Date
_____ / _____ / _____

Cardholder Name
_____

Signature
_____

Billing Zip _____

I (we), the undersigned, authorize and request Z Medi Spa to charge my credit card, indicated above, for balances due for services/cancellations rendered that is my financial responsibility.
This authorization will remain in effect until I (we) cancel this authorization.
Patient Name (Print):
_____

Signature
_____

Date _____ / _____ / _____

Fitzpatrick Skin Analysis Worksheet

Score	Questions	0	1	2	3	4
	What is the color of your eyes?	Lt Blue, Gray or Green	Blue, Gray, or Green	Blue	Dark Brown	Brown Black
	What is your natural hair color?	Sandy Red	Blonde	Chestnut Brown, Dark Blonde	Dark Brown	Black
	What is your skin color on unexposed areas?	Reddish	Very Pale	Pale with beige tint	Light Brown	Dark Brown
	Do you have freckles on sun exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Pain, Redness, Blistering, Peeling	Blistering followed by peeling	Burns sometimes with peeling	Rarely Burn	Never burn
	To What degree do you turn brown?	Rarely or not at all.	Light color tan.	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown after several hours in the sun?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very Sensitive	Sensitive	Normal	Very resistant to sun	Never had a problem
	When did you last expose your skin to the sun, tanning bed, or self-tanning creams?	More than three months ago.	2-3 months ago	1-2 months ago.	Less than one month ago	Less than two weeks ago.
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
Total Score / Skin Type	Score Fitzpatrick Skin Type 0-7 I 8-16 II 17-25 III 26-30 IV > 30 V and VI					

Name_____ Date_____