Skincare Medical History and Treatment Consent

Client Name:____Date:__________________

Email:____ __________ DOB:_______________________________

Address: ____

Phone:____________________________________ Preferred contact method: **Phone** **Text** **Email**

Occupation:______________________________ May I send you occasional special offers via mail/email? **Yes** or **No**

What are your preferred personal pronouns? She / Her / He / Him / They / Them Other:___________________

Emergency Contact: ____

Relation: __________________________________ Phone:____

Have you had professional skin care &/or spa services before? **Yes** or **No**. If yes, how long ago?__________________

Are you currently under the care of a physician or dermatologist? **Yes** or **No .** If yes, please explain:________________

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Please list any medication (prescription or over-the-counter) that you take regularly, including oral contraceptives:____

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Please list any recent Surgeries (including cosmetic)/ Major Illnesses: ____

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Do you have any of these conditions that may impact our session? Please answer honestly, as some treatments may not be safe to receive under certain circumstances. :

fever **infection** **contagious disease** **blood clots** **congestive heart failure** **pitting edema**

Check all that apply:

- ○ Cancer (please describe):
  ____
  ____
- ○ Headaches/Migraines
- ○ Open cuts/sores/lesions
- ○ Skin Sensitivities
- ○ Eczema
- ○ Psoriasis
- ○ Keloid Scarring
- ○ Bruises
- ○ Arthritis
- ○ Seizures/Epilepsy
- ○ Fibromyalgia
- ○ Neurological Problems
- ○ Depression/Anxiety
- ○ Lymphedema
- ○ Asthma
- ○ Thyroid/Endocrine Dysfunction
- ○ Diabetes
- ○ Cardiovascular Problems
- ○ Varicose Veins
- ○ Pacemaker
- ○ Metal Implants
- ○ Blood Pressure Problems
- ○ Autoimmune Disease
- ○ HIV/AIDS
- ○ Cold Sores/Fever Blisters
- ○ Hepatitis
- ○ Aversion to Smells
- ○ Aversion to Heat/Cold

Are you under the influence of drugs and/or alcohol?
Yes ☐ No ☐

Are you pregnant?
Yes ☐ No ☐

If Yes, How many weeks?______

Are you breastfeeding?
Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐

Other Conditions: ____

Have you used Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products in the past 3 months? Yes ☐ No ☐ If yes, list which:__________________________________

Do you follow a restricted diet (some products contain milk derivatives)? Yes ☐ No ☐ ___________________________

Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes ☐ No ☐

How frequently are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___Regularly

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout

Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Salicylic Acid Glycolic Acid Fragrance Shellfish Latex Drugs Other: ________________

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Thank you for taking the time to fill out this questionnaire! This information helps me to tailor your session to your needs and ensure that you have the best experience possible.

Notes:____

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Consent for Treatment

If I experience **any pain or discomfort during this session, I will immediately inform the treatment provider so that the treatment can be adjusted** to my level of comfort. I further understand that esthetic/skin care services should **not be construed as a substitute for medical examination, diagnosis, or treatment** and that I should see a physician, dermatologist, or other qualified medical specialist for any mental or physical aliment of which I am aware. I understand that **my treatment provider is not qualified to diagnose, prescribe or treat any physical or mental illness**, and that nothing said in the course of the session should be construed as such. Because skin care treatments should not be performed under certain medical conditions, I affirm that I have **stated all known medical conditions** and **answered all questions honestly**. I agree **to keep my treatment provider updated** as to any changes in my medical profile and understand that there shall be no liability on the part of the provider *s*hould I fail to do so. I also understand that ***any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and all future sessions, and I will be liable for payment of the scheduled appointment***. Understanding all of this, I give my consent to receive skin care and spa treatments.

Print Name: ____ Date: _____________

Signature: ____

Treatment Provider Signature:____

Privacy Policy

Emily Marie Miller, LMT of *Massage Therapy by Emily Miller, LLC (DBA Little Moon Massage Therapy & Doula Services)* will keep client communication and information confidential and will not share client information without the client's written consent, within the limits of the law. *Massage Therapy by Emily Miller, LLC* will ensure every effort is made to respect the client's right to privacy and provide an environment where personal health-related details cannot be overheard or seen by others.

Cancellation Policy

Because your appointment time is reserved exclusively for you, at least 4 hours notice of cancellation is required or the full charge of the session applies. Exceptions will be made for emergencies at the provider's discretion.