

Inner Essence Spa Confidential Skin Care History

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone (home) _____ (cell) _____ cell
carrier _____

Occupation: _____

Therapist Gender Preference (circle) **NO YES**

How did you hear
about Inner Essence Spa? _____

Have you had a professional facial/body treatment before? **NO YES**

Emergency Contact Info

Name: _____ Relationship: _____

Phone: _____

Email: _____

Are you taking any medications? **NO**

YES (list) _____

Previous

Surgeries: _____

List anything related to your current health

status: _____

Are you under a dermatologists care? **NO YES**

If yes, is your dermatologist aware you are receiving treatment from us? **NO YES N/A**

In the last 6 months, have you used any of the following (circle) Azelex, Differin, Tazarac, Renova, RetinA, Accutane, AHS's

If yes to any please enter the date you used: _____

Have you had any cosmetic surgery? **NO YES**

If yes, please state the type and date of

surgery _____

Are you taking birth control pills? **NO YES**

Are you taking hormone replacement therapy? **NO YES**

Do you wear contact lenses? **NO YES**

Do you smoke? **NO YES**

Do you have any allergies to cosmetics, foods or drugs? **NO YES**

If yes, please list _____

Please circle what products you currently use; cleanser, toner, scrub/exfoliant, mask, moisturizer, sunscreen, serum, other _____

Are you affected by or have any of the following (circle) Skin Diseases, Herpes, Simplex, Asthma, Epilepsy, Cardiac Problems, Pacemaker, Metal Pins/Implants, Pregnancy, other

If you circled any of the above please
explain_____

Are you diabetic? **NO YES**

Inner Essence Spa LLC is not responsible for the aggravation of conditions, which were present, but not disclosed to the practitioner, at the time of service received and which may be affected by the service. Inner Essence Spa LLC is not responsible for any condition, which may/may not have resulted from experiencing services at our facility. By signing, you are stating that you fully understand the above questions and authorize treatment.

Signature:_____

Date:_____