Health History Intake Form

Date: ______________
Name: _____________________________________
Date of Birth: ______________ Age: ____
Address: ____
Phone: ____________________ Email Address: _______________________

Allergies: ___________________________
Current medications (topical & oral): ______________________________________

Have you ever experienced any of the following conditions?
(Circle all that applies)

Cancer Diabetes Hysterectomy AIDS/HIV Psoriasis Spinal Injury Keloid Scarring
Menopause High/Low Blood Pressure Claustrophobia Hormone Imbalance Hepatitis A/B/C
Rosacea. Cold Sores Blood Clot Disorder Circulation Disorder Metal Implants/Pins
Heart Disease Epilepsy/Seizures Migraines/Headaches Eczema
Immune Disorder Skin Disease/Disorder Varicose Veins/Phlebitis Pacemaker/Defibrillator
Thyroid Disorder Blush/Redden Easily Depression/Anxiety Bruise Easily Lupus
Fibromyalgia
Other: ____

Do you smoke? Y | N
Do you wear contacts? Y | N
Do you follow a restricted diet? Y | N
What is your daily consumption of Water? ___oz Caffeine? __oz Alcohol? __oz

Are you currently under the care of a physician or dermatologist? Y | N If so, explain:
____
Any surgeries within the last 6 months? Y / N If so, explain:
____
Any dermal injections/fillers with in the last 6 months? Y / N If so, explain:
____
Are you using any products that contain Retin -A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A, Accutane or any other prescription or over the counter skin product? Y / N
Have you used any of these products in the past 3 months? Y / N If so, explain:
____
Have you ever had any allergic reaction to any skin products? Y / N If so, explain:
____

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Client Consent:

I understand, have read and completed the questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in giving better service and is completely confidential. The treatments I receive here are voluntary and I release BodiSnatcher LLC, it's staff, Management and Owner Nikki Smithers from any liability and assume full responsibility of thereof.

Patient Signature:

Date: