

CLIENT HEALTH HISTORY



CLIENT HISTORY

DATE: _____

NAME: _____
First m. Last

ADDRESS: _____

PHONE: HM _____ WK _____ CELL _____

DATE OF BIRTH _____
Month day

Under 21
 21-30
 31-40
 41-50
 Over 50

REFERRED BY: _____

1. Are you currently or within last year under a physician's care? Have you undergone any surgery In the last 9 months? If yes, specify _____	Yes	No	Regular Check- ups?		
2. Do you see the Dentist regularly?	Yes	No	Recent Dental X- rays?		
3. Have you had any of these health issues in the past or present? (Please circle)					
Cold Sores	Heart Problems	High Blood Pressure	Cancer	Diabetes	Epilepsy
Lungs	Psoriasis/Eczema	Weight loss/gain	Stress	Nervous Disorder	Arthritis
Digestion/GI	Elimination	HIV, Aids, STD	Depression	Rosacea	Fatigue
Lupus	Muscle Tension	Hormone Imbalance	Hysterectomy	Thyroid	Varicose Veins

Back/Sciatica	Asthma	Urinary Tract	Sinus	Fibromyalgia	MS	
4. List any medications and herbal supplements you take regularly:						
Medications:			Herbal Supplements:			
List any vitamin or mineral supplements you take regularly:						
Vitamins:			Minerals:			
5. Do you ?					Yes	No
Smoke (cigarettes, cigars, pipe, controlled substance)						
Use controlled substance						
Follow restricted diet If yes, explain						
Have regular sleep patterns						
Drink water If yes, daily intake _____						
Exercise regularly? If yes, type of activity _____						
Use Retin-A						
Use depilatories						
Ever used Accutane? (acne drug)						
Take stimulants or diuretics						
Drink alcoholic beverages If yes, how many						
Have chemically treated hair						
Wear contact lenses						
6. Have you ever had a reaction to?						
Please circle						
Dust	Pollen	Animals	Wool/fabrics	Plants		
Foods	Cosmetics	Medicine	Iodine	AHAS		
Sunscreens	Fragrance	Other				
7. Do you take any contraception/hormones?				Yes, specify	No	
Are you pregnant, lactating, or trying to become pregnant?				Yes, specify	No	
Are you experiencing pre-menopausal symptoms?				Yes, specify	No	
Are you currently or due for menstruation?				Yes, specify	No	
8.					Yes	No
Do you use sunscreen						
Do you burn easily in moderate sunlight?						
Do you blush easy when nervous?						
Do you have a tendency to redness?						
Have you ever experienced claustrophobia?						
What level is your pain threshold?			Low	Medium	High	

9. Do you work in or outside the home?	Yes, specify	No	
Describe your environment: Work: Live:			
10. Do you have any special skin problems pertaining to your face?	Yes, specify	No	
11. Do you have any special concerns pertaining to your body?	Yes, specify	No	
12. What types of skin, body, and hygiene products do you use? _____ _____ _____			
13. Do you have any special concerns pertaining to habits/lifestyles?	Yes, specify	No	
14. Do you have any hobbies? List.			
15. Anything personal you would like to share?			

