



*Welcome to Body Essence, in order to better serve you we would like you to provide us with some basic information about yourself.*

***\*PLEASE PRINT CLEARLY\****

*Name* \_\_\_\_\_

*Address* \_\_\_\_\_

*City/Zip Code* \_\_\_\_\_

*Phone Circle:(Home/Work/Cell)* \_\_\_\_\_

*Birthday* \_\_\_\_\_

*Anniversary* \_\_\_\_\_

*Please provide an E-Mail if you would like us to send you our Monthly Specials/Newsletter:* \_\_\_\_\_

*May we contact you for confirmation calls?* \_\_\_\_\_

*How did you hear about us? (check all that apply)*

*Friend (provide name)* \_\_\_\_\_ *Website*\_\_ *Radio*\_\_ *TV*\_\_  
*Newspaper*\_\_ *Drive-by*\_\_ *Other* \_\_\_\_\_

*Thank you, we hope your experience at Body Essence will be relaxing and refreshing.*

# Patient Profile

Patient ID#: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date \_\_\_\_\_

## PLEASE CIRCLE OR FILL IN THE APPROPRIATE ANSWER

- Previous medical conditions:
- Medications you are taking:
- Are you allergic to any medications? Yes No -If Yes, please list:
- Are you pregnant or lactating? Yes No
- Do you wear contact lenses? Yes No
- Do you have permanent makeup? Yes No To what area of the face? \_\_\_\_\_
- Do you currently use or receive waxing? Yes No (Discontinue 7 days before treatment)
- Do you currently have sunburn/windburn/or a red face? Yes No Why? \_\_\_\_\_
- Are you in the habit of going to tanning booths? Yes No (If within past 14 days, decline treatment)
- Are you applying any topical medications at this time? Yes No Which Ones(s)? \_\_\_\_\_
- Are you currently using any topical retinoid prescriptions? Yes No What Strength? \_\_\_\_\_ For how long? \_\_\_\_\_ (Discontinue use 5 days before any treatment)
- Are you using Accutane? Yes No For how long? \_\_\_\_\_
- Have you ever had a chemical peel or any type of procedure with a medical device? Yes No Within 14 days? Yes No Describe \_\_\_\_\_
- Do you have regular collagen, Botox, or other dermal injections? Yes No (Peels may follow after 2 days)
- Have you had facial surgery? Yes No Describe \_\_\_\_\_ How long ago? \_\_\_\_\_
- Have you had laser surfacing? Yes No When? \_\_\_\_\_ What type? \_\_\_\_\_
- What type of work do you do? \_\_\_\_\_ Regular Air travel? Yes No
- Do you participate in vigorous aerobic activity or sports? Yes No
- Do you smoke or use tobacco? Yes No
- Do you develop cold sores or blisters? Yes No
- Are you allergic/sensitive to: (Circle all that apply) Milk Apples Citrus Grapes Aloe Vera Aspirin Seafood Perfumes Latex Hydroquinone Mushrooms Lidocaine Other: \_\_\_\_\_
- Are you sensitive to alcohol based products? Yes No
- Have you ever used any products that cause a bad reaction? Yes No Describe \_\_\_\_\_
- Are you taking any medication at this time? Yes No What kind? \_\_\_\_\_
- Are you currently using any mood altering medications? Yes No What kind? \_\_\_\_\_
- What is your Hereditary/Ethnic Background? \_\_\_\_\_
- Do you consider your skin: Resilient Sensitive Unsure
- Describe your skin: (Circle) Normal Oily Dry Combination Thin Saggy Acne Blackhead Whiteheads Freckled Eczema Melasma Mature Wrinkled Sallow Dehydrated Rosacea Sun Damaged Large Pores Uneven Red Other: \_\_\_\_\_
- What skin care products are you currently using at home? Please describe.

○ Cleanser:

○ Toner:

○ Mask:

○ Treatment Product:

Please turn over

- Moisturizer:
- SPF
- Makeup:
- Scrub

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that treatment should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated.

Patient Name \_\_\_\_\_ Patient Signature \_\_\_\_\_

Legal Guardian Name \_\_\_\_\_ Legal Guardian Signature \_\_\_\_\_  
(If patient is under 18)

Date: \_\_\_\_\_