Junto Spa Health History

Date: ______________________

Name ______________________________________ Date of Birth ________________

Address __________________________ City/State: ________________ Zip: ________

Home Phone ________________________ Cell Phone __________________________

Email _____________________________ Business Phone _______________________

Physician __________________________________ Phone _____________________

Emergency Contact ___________________________ Phone _____________________

Who may we thank for referring you? ____

Your Health

Have you been under the care of a physician, dermatologist or other medical professional within the past year? ◯ No ◯ Yes, explain: ____

Any recent surgery, including plastic surgery? ◯ No ◯ Yes, explain: ____________________

Have you had permanent cosmetics? ◯ No ◯ Yes, what area?: ______________________

Have you had any of these health conditions in the past or present? (Check all that apply)

- ◯ Cancer _________________________
- ◯ Hormone Imbalance
- ◯ Hysterectomy
- ◯ Systemic disease: ________________
- ◯ High Blood Pressure
- ◯ Spinal Injury: ___________________
- ◯ Thyroid Condition: _______________
- ◯ Diabetes
- ◯ Heart Problem: __________________
- ◯ Varicose Veins
- ◯ Arthritis
- ◯ Asthma
- ◯ Eczema
- ◯ Epilepsy/Seizure disorder
- ◯ Headaches/Migraines
- ◯ Hepatitis
- ◯ Herpes
- ◯ Frequent cold sores
- ◯ Immune Disorders: _______________
- ◯ HIV/AIDS
- ◯ Lupus
- ◯ Metal implants, pins or plates
- ◯ Phlebitis, blood clots, poor circulation
- ◯ Bleeding disorder
- ◯ Insomnia
- ◯ Keloid scarring
- ◯ Skin disease/skin lesions: ___________
- ◯ Any active infection: ______________

Do you smoke? ◯ No ◯ Yes

Do you follow a restricted diet? ◯ No ◯ Yes, specify: ____________________________

Do you have any aversion to the use of essential oils (EO) in your treatment? ◯ No ◯ Yes

If yes, which oils bother you? ____

(I use EO's in many of my treatments, if you would like this omitted please write "ALL" above)

Are you currently taking or have you taken antibiotics in the last 2 weeks? ◯ No ◯ Yes

List any medications you take regularly including OTC medications, vitamins, herbal supplements, etc: ____

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Do you use Retin-A, Renova, Adaplene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin derivative products in the last 6 months? ◯ No ◯ Yes

Have you used an acne medication in the last 6 months? ◯ No ◯ Yes, What?________________

Do you form thick or raised scars from cuts or burns? ◯ No ◯ Yes

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ◯ No ◯ Yes, describe: ____________________

Do you wear contact lenses? ◯ No ◯ Yes

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

Do you have a pacemaker? ◯ No ◯ Yes

Do you suffer sinus problems? ◯ No ◯ Yes

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

Cosmetics	Medicine	Food	Animals	Sunscreens	Iodine	Shellfish
AHA's	Fragrance	Pollen	Latex	Other: ____________________		

Female Clients Only

Have you gone through Menopause? ◯ No ◯ Yes (If Yes – skip to signature)

Are you pregnant or trying to become pregnant? ◯ No ◯ Yes

Are you lactating? ◯ No ◯ Yes

Release For Treatment

I understand, have read and completed this 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/body from treatments received. I am aware that it is my responsibility to inform the aesthetician/massage therapist or laser technician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or the professional technician from liability and assume full responsibility thereof.

Client Signature: ______________________________ Date: __________________