Junto SKIN & LASER Health History & Consent for Treatment

Date: _____

Name _____ Date of Birth _____

Address _____ City/State: _____ Zip: _____

Home Phone _____ Cell Phone _____

To receive text message appointment reminders please provide cell service carrier: _____

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 or dermatologist or other medical professional in the past year?

No Yes, explain: _____

Any recent surgery, including plastic surgery? No Yes, explain: _____

Have you had permanent cosmetics? No Yes in what area(s)?: _____

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 have a pacemaker? 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) _____

When was your last *significant* exposure to sun or tanning beds? _____

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, Which? _____

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 Where? _____

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 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: _____