

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR YOUR SKIN?

IF YES, PLEASE EXPLAIN:

HAVE YOU EVER SEEN A DERMATOLOGIST OR OTHER PHYSICIAN FOR YOUR SKIN?
IF YES, PLEASE EXPLAIN:

HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER? YES NO

If yes, who? _____ *Anatomical location:* _____

What type of skin do you have?

- _____ I. light white skin; always burns, never tans
- _____ II. light white skin; always burns, sometimes tans
- _____ III. medium white skin; sometimes burns, always tans
- _____ IV. dark/olive white and Asian skin; rarely burns, always tans
- _____ V. light-brown skin
- _____ VI. medium to dark-brown, African and African-American skin

DO YOU USE SUNBLOCK? YES NO **WHAT SPF?** _____

ARE YOU TAN NOW? YES NO **DO YOU USE A TANNING BED?** YES NO **LAST TIME IN SUN?** _____

HAVE YOU BEEN HOSPITALIZED FOR ANY REASON? _____

IF YES, PLEASE EXPLAIN _____

PLEASE CIRCLE IF YOU HAVE OR EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING

Heart Disease/Trouble	Diabetes	Glaucoma	Skin problems	Emotional/ Psychiatric problems
High blood pressure	Jaundice/ Liver problems	Cancer	Scarlet/ Rheumatic Fever	Sleep Apnea
Low blood pressure	Dental problems/TMJ	Anemia	Kidney/Bladder problems	Gall Bladder Problems
Asthma	Headaches/Migraines	Bleeding Disorders	Keloid scars	Motion Sickness
Lung problems	Leg, Back, or Neck pains	Convulsions	Blood clots	Oral Herpes Simplex (Cold sores)
Shortness of breath	Fainting	Kidney problems	Stomach/ Intestinal	Genital Herpes
HIV/AIDS	Hepatitis A, B or C	Thyroid Disorder	Vitiligo	Circulatory Disorders/Vascular Problems
Ringing in ears	Chest Pain	Shortness of Breath	Tuberculosis	Ulcer/Gastrointestinal Problems
Indigestion	Varicose Veins	Skin/Hair disorders	Upper Respiratory Problems	Sleeping Problems
Arthritis	Neck/Shoulder problems	Herniated Disc	Pinched Nerve	Painful/Swollen joints
Leg pain or numbness	Swollen Ankles	Cold hands/feet	Car Accident	Numbness/pain of arms and or hands
Broken Bones	Whiplash	Fatigue	Depression	Dizziness/Loss of Balance

IF YOU HAVE CIRCLED ANY OF THE ABOVE, PLEASE EXPLAIN: _____

FAMILY HISTORY

List any family history of significant illness (for example: heart disease, diabetes, melanoma, malignant hyperthermia, breast cancer)

PLEASE ELABORATE ON ANY MEDICAL INFORMATION THAT MIGHT BE HELPFUL.

ARE THERE OTHER SERVICES YOU WOULD LIKE TO DISCUSS?

LASER HAIR REMOVAL	<input type="checkbox"/>	LASER 360	<input type="checkbox"/>	PIXEL PERFECT	<input type="checkbox"/>
CHEMICAL PEELS	<input type="checkbox"/>	ACCENT RF	<input type="checkbox"/>	IPL/PHOTOFACIAL	<input type="checkbox"/>
LASH & BROW TINTING	<input type="checkbox"/>	FILLERS	<input type="checkbox"/>	BOTOX/DYSPORT	<input type="checkbox"/>
THIN LIPS/SMOKER'S LINES	<input type="checkbox"/>	SUN DAMAGE	<input type="checkbox"/>	EYELASH EXTENSIONS	<input type="checkbox"/>
ENLARGED PORES	<input type="checkbox"/>	WAXING	<input type="checkbox"/>	MASSAGE	<input type="checkbox"/>
MICRODERMABRASION	<input type="checkbox"/>	FACIALS	<input type="checkbox"/>	SCAR REDUCTION	<input type="checkbox"/>
BROKEN CAPILLARIES	<input type="checkbox"/>	AGE SPOTS	<input type="checkbox"/>	MASSAGE	<input type="checkbox"/>
SKIN CARE PRODUCTS	<input type="checkbox"/>	SCAR REDUCTION	<input type="checkbox"/>	SPIDER VEINS	<input type="checkbox"/>
NON-SURGICAL EYE LIFT	<input type="checkbox"/>	ROSACEA	<input type="checkbox"/>	AGE REJUVENATION	<input type="checkbox"/>

****FOR WOMEN:**

DO YOU SUSPECT YOU MAY BE PREGNANT? Y N

ARE YOU PREGNANT OR LACTATING? Y N

ARE YOU TRYING TO BECOME PREGNANT? Y N

IF EVER PREGNANT, DID YOU EXPERIENCE HYPERPIGMENTATION OR "PREGNANCY MASK"? Y N

****CONSULTATIONS FOR SKIN CARE PATIENTS & LASER 360, PIXEL, ACCENT, IPL:**

HAVE YOU PREVIOUSLY HAD A CHEMICAL PEEL? _____

DATE OF LAST PEEL? _____

HAVE YOU EVER HAD A LASER RESURFACING, DERMABRASION OR MICRODERMABRASION? _____

TYPE/DEPTH (IF KNOWN): _____ DATE: _____

HAVE YOU EVER HAD FACIAL SURGERY? YES NO IF YES, PROCEDURE _____ DATE? _____

HAVE YOU HAD AN AGGRESSIVE EXFOLIATION TO YOUR SKIN IN THE LAST TWO WEEKS? YES NO

IF YES, PLEASE EXPLAIN: _____

WHAT SKIN CARE PRODUCTS DO YOU CURRENTLY USE? (i.e. alpha-hydroxy products, Retin-A, glycolic/salicylic acid etc.) _____

****CONSULTATIONS FOR LASER HAIR REMOVAL/VEIN REMOVAL PATIENTS:**

WHAT AREA(S) ARE YOU INTERESTED IN TREATING? _____

HAVE YOU EVER HAD LASER HAIR REMOVAL AND/OR VEIN TREATMENT(S)? Y N

IF YES, WHAT AREA(S)? _____ WHEN: _____

REACTION, IF ANY? _____

WHAT TYPE OF LASER WAS USED? _____

LIST ANY PREVIOUS TYPES OF HAIR REMOVAL: (i.e., LHR, waxing, shaving, electrolysis, depilatories, bleaching, etc.) _____

REACTION FROM ANY OF THE ABOVE, IF ANY? _____

WHEN WAS THE LAST TIME YOU WAXED, USED A DEPILATORY, TWEEZED OR THREADED THE AREA(S) OF CONCERN? _____

PLEASE EXPLAIN: _____

****CONSULTATIONS FOR MASSAGE PATIENTS ONLY:**

PATIENT'S GOALS: _____

Why are you seeking massage therapy at this time? Personal Enjoyment Stress Pain or Injury Gift Certificate

MAJOR SYMPTOMS? (If you are currently experiencing pain or discomfort, please describe you major symptoms).

PLEASE EXPLAIN: _____

MINOR SYMPTOMS: (Please describe other areas of pain or concern) _____

WHEN DID YOU NOTICE YOUR SYMPTOMS? _____

DO YOU KNOW WHAT BROUGHT IT ON? Y N

WHAT ACTIVITIES CONTINUE TO AGGRAVATE THE SYMPTOMS? _____

STATUS OF CONDITION (circle all that apply):

Getting Worse Getting Better Staying the Same Pain is Constant Pain Comes and Goes

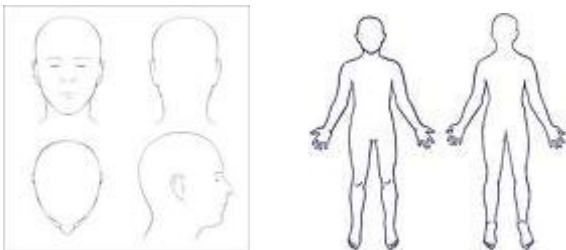
IS THE CONDITION INTERFERING WITH YOUR? : (circle all that apply): work sleep daily routine

IS THERE A MEDICAL DIAGNOSIS? Y N IF YES, WHAT IS THE DIAGNOSIS? _____

NAME OF PHYSICIAN _____ PHONE NUMBER _____

HAVE YOU EVER BEEN IN A CAR ACCIDENT? Y N IF YES, DID YOU EXPERIENCE WHIPLASH? Y N

ON THE FIGURES BELOW, PLEASE SHADE ANY AREAS WHERE THERE IS PAIN OR STIFFNESS.



All PATIENTS, PLEASE SIGN & DATE:

PATIENT NAME: _____

PATIENT SIGNATURE _____ DATE: _____

WITNESS/GUARDIAN: _____ DATE: _____

WITNESS/GUARDIAN SIGNATURE: _____ DATE: _____

FOR OFFICE USE:

REVIEWING PROVIDER SIGNATURE:

_____ DATE: _____

Michelle Hightower, R.N Collette Balbaro, LE Joelle Circio, LMT
Jaime Richardson, R.N. Charity Currin-Allen, LE

REVIEWING PHYSICIAN SIGNATURE: _____ DATE: _____

Dr. Russell, Dr.Carlino, Dr.Oschwald