

Fallsgrove MediSpa

Client Questionnaire

Today's Date _____

Name _____ e-mail _____

Address _____

_____ Phone _____

Condition for which you are seeking service today: _____

Have you seen a dermatologist or other physician for this or any other skin condition? Yes or No.

If yes, please explain: _____

Do you have any medical conditions for which you are being treated or medically monitored at this time? Yes or No. If yes, please explain _____

Are you pregnant? If so, how many months? _____

Do you have any implanted electronic device such as a pacemaker? _____

HISTORY – PLEASE CIRCLE YES OR NO AFTER EACH QUESTION

Do you have any allergies? Yes No If yes, please specify: _____

Have you ever smoked? Yes No If yes, when and for how long? _____

Have you ever had any of the following?

Previous facials? Yes No If yes, when? _____

Botox Injection? Yes No If yes, when? _____

Restylane Injections? Yes No If yes, when? _____

Facial Surgery? Yes No If yes, when? _____

Dental Surgery,

Implants, etc.? Yes No If yes, when? _____

Facial or jaw pain? Yes No If yes, when? _____

Neck Surgery? Yes No If yes, when? _____

Please list medications that you currently are using (prescription, supplements, or over the counter):

Our MediSpa services do not constitute medical treatment for any condition. Our MediSpa services are for cosmetic purposes only. _____

Client Signature