On the Go Wellness Spa medical questionnaire & consent

Name _____ Date of Birth _____

Phone # _____ Address: _____

Email: _____ M/F

Services Performed : For office

Facial Massage Therapy Waxing Lashes Detox Body Wrap Body Sculpting Teeth Whitening Other

Please read and answer all questions to the best of your knowledge and ability. It is important for your safety and treatment of your skin to answer honestly.

Are you Pregnant Are you Nursing Do you smoke cigarettes

Do you have any Allergy's to food or Aspirin? Please List: _____

Have you EVER had or are prone to any of the following? Y/N **(please circle all that apply)**

Cold sores Hives Keloids Rash

If so how often: _____ Is it active now?

Last breakout: _____ Area of breakout: _____

Do you suffer from chronic pain? Y/N

If yes, please explain: _____

What makes it better? _____

What makes it worse?_____

Have you had any orthopedic injuries? Y/N

If yes, please list: _____

Please circle any of the following that apply to you:

Cancer Fibromyalgia Headaches/Migraines Stroke Arthritis Heart Attack Diabetes Numbness Kidney Dysfunction Joint Replacement(s) Blood Clots High/Low Blood Pressure Neuropathy Sprains or Strains Poor Circulation Pacemaker Liver Issues

Have you visited a tanning bed in the last 72 hours? Y/N

Do you Exfoliate? Y/N If yes, last time: _____ How often? _____

List all medications currently taking, including vitamins and birth control:

_____

Are you currently taking Antibiotics? Y/N

Have you had any problems with your heart or lungs? Y/N

(Some medications can increase sensitivity)

Have you had any surgery's in the last 12 months, INCLUDING Cosmetic? Y/N

If yes, what kind and when:

_____

Are you currently using products that contain AHA, Retin-A, Retinoids, Retinols? Y/N

If yes, last timed used? _____ how often times per week?

Have you ever used Accutane? Y/N If yes, last dose:

Have you ever had a reaction to any skin care products? Y/N

If yes, what and when? _____

Have you had any of the following services in the last week? Y/N **(please circle all that apply)**

Microdermabrasion Chemical Peel Collagen Botox Waxing

If yes, when? _____

What improvements would you like to see in your skin?

_____

_____

_____

Please circle what you currently do daily for your skin:

Cleanse Exfoliate Toner Serum Eye treatments Mask Moisturize

What products do you currently use:

_____

Do you wear sunscreen? Y/N If yes, what strength is the SPF? _____

Consent Agreement

I affirm that I have stated, to the best of my knowledge and ability that all of my known medical conditions have been disclosed and answered on this form correctly and honestly. I agree to hold harmless and without liability or lawful action toward On the Go Wellness Spa and all of their affiliates. I understand to keep On the Go Wellness Spa/affiliates updated as to any changes in my personal profile including medical, medications, treatments and lifestyle changes and fully understand that there shall be no liability held in any case or damages. By signing below I agree to allow the use of my pictures, videos, and any means of advertisement for marketing purposes for On the Go Wellness spa/affiliates. I also fully understand all complications and risk associated with all services rendered and treatments provided associated with but not limited to: dermaplaning, microdermabrasion, chemical peels, electrolysis, Eyelash Extensions, Eyelash Tinting and Waxing and hold On the Go Wellness Spa/affiliates harmless of all damages.

Printed Name _____ Signature _____ Da**te _____**