SPA
WITHIN

Client Evaluation Form

Client Name:	Phone Number:
Address:	Cell Number:
Please indicate: ❑ Male ❑ Female	Email:

MEDICAL HISTORY

Do you have any chronic medical conditions which we should know about? Yes No
If so, please list: _____

Do you have any allergies to latex, medications, nuts food or herbal or natural supplements? Yes No
If so, please list: _____

Do you have, or have you had, any changes in medical history recently? Yes No
Please list any and all current/past surgeries, surgical procedures or injuries or accidents. _____
_____
_____

Have your taken Accutane within the past year? Yes No

Are you on any anticoagulants, daily Aspirin, Motrin or Advil? Yes No

Are you a smoker? Yes No

Do you have veneers on your teeth? Yes No

Do you have a history of cold sores*, fever blisters or herpes 1 or 2? Yes No

If so, when was your last outbreak? _____*the use of some equipment can trigger an outbreak.

Do you have a history of hypo/hyper-pigmentation? Yes No

Have you ever been treated with a laser, microdermabrasion, chemical peel, or injection? Yes No

If so, please list: _____

What skin care products are you currently using?_____

Are you happy with your skin care products? Yes No

Do you or have you used any topical medications or creams such as:

Retin-A, Renova, Tazorac, Differin, Obagi, or any others? Yes No

If so, please list: _____

When was the last time you used these medications? _____

Do you have permanent makeup or tattoos? Yes No

If so, please list: _____When was your last treatment:

_____

Are you Claustrophobic? Yes No

Are you wearing Contact Lenses? Yes No

Have you ever had a reaction to a cosmetic or skin care product? Yes No

Please describe:_____

Please tell us about your skin (Check all that applies):

o	Normal	o	Acne	o	Hyper-pigmentation
o	Dry	o	Large Pores	o	Hypo-pigmentation
o	Oily	o	Melisma	o	Broken Capillaries

Additional information you would like your technician to know: _____

_____

_____

I understand fully and agree to comply with all the Spa policies listed below:

1. We do not wax anyone on Accutane, Retain-A, or other medications/products that exfoliate or thin skin.
2. We do not wax anyone undergoing chemotherapy or radiation treatments.
3. We require 24 hours advance cancellation. Any client giving less will be charged that full fee of service reserved.
4. I understand that the services received here are not a substitute for medical care and any information provided by the technician is for education purposes only.
5. All information received by the client on this folder is completely private and confidential. All information provided by the client on this folder is true to the best of their knowledge.
6. We do not give cash refunds.

Client signature:_____

Women Only:

Are you or could you be pregnant?	Yes	No
Are you currently breast-feeding?	Yes	No
Are your menstrual cycles normal?	Yes	No