**SILENT DREAM**

**Confidential Client Health History Form**

**The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.**

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| **Name:** | **Date Of Birth** |
| **Address:** |  |
| **E-mail** | **Phone:** |
| **Physician:** | **Phone:** |
| **Emergency Contact:** | **Phone:** |

**Your Health:**

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| **Have you been under the care of a physician, dermatologist or other medical professional within the past year?** |
| **Any recent surgery, including plastic surgery?** |
| **Have you had any piercings, tattoos, or permanent cosmetics?** |
| **Have you ever had beauty treatments before? i.e Waxing; botox; facial; massage…please advise of any allergies.** |

**Have you had any of these health conditions in the past or present? (Please tick all that apply and provide additional information in the space provided)**

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| **Cardio Vascular**   * **Heart Disease** * **Varicose Veins** * **High/Low Blood Pressure** * **Blood Clots/Bruising** * **Poor Circulation** * **Stroke/CVA/TIA** * **Pacemaker** * **Thrombosis/Embolism**   **Women’s Health**   * **Menopause** * **Hysterectomy** * **Painful Periods** * **Pregnant** * **Lactating**   **Respiratory**   * **Asthma** * **COPD/Emphysema** * **Bronchitis** * **Chronic Cough** * **Shortness of Breath** | **Other**   * **Loss of Sensation** * **Cancer** * **Physiological Treatment** * **Insomnia** * **Hormone Imbalance** * **Thyroid** * **Epilepsy/Seizures** * **Diabetes** * **Headaches** * **Migraine** * **Bruising/Swellings** * **Recent Scar Tissue** * **Cuts/Abrasions** * **Recent Injuries** * **Problems with Nervous System** * **Botox** * **Failed Skin Sensitivity Test** | **Musculoskeletal**   * **Spinal Injury** * **Arthritis** * **Metal Pins or Plates** * **Rheumatism**   **Infections**   * **Hepatitis** * **TB** * **Lupus** * **Herpes** * **HIV/AIDS**   **Skin Conditions**   * **Impetigo** * **Ringworm** * **Malignant Melanoma** * **Frequent Cold Sores** * **Warts/Moles** * **Eczema/Psoriasis** |

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| **Do you smoke?** | **Do you follow a restricted diet?** |
| **Do you suffer from sinus problems?** | **Do you follow a regular exercise programme?** |
| **Do you experience any problems sleeping?** | **What is your stress level? (Please circle)**  **High Medium Low** |

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| **Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)**  **…Rash…..Irritation….Peeling…..Sun Sensitivity…..Breakout** |
| **Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)**  **Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs Fragrance Shellfish Latex Drugs** |
| **List any medications you take regularly (Please include over the counter medicine, vitamins and herbal supplements** |
| **How would you describe your general health?** |

**Please use this space to complete answers where space was insufficient. (Please include the number of the question) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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 from treatments received. I am aware that it is my responsibility to inform the therapist 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 skin care professional from liability and assume full responsibility thereof.**

**Future Appointments/Contact:**

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| * **May we telephone you to confirm future appointments?** | * **May we contact you via SMS/email about future promotions and news?** |

**Photographs**

I authorise the taking of photographs and video footage which will be retained as a private record for the clinic and practitioner. I also consent the use of my photographs and video footage free of charge for marketing purposes.

Client’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_