Body Bliss
Wellness Center

First Name: _____ Last Name: _____ Date of Birth: _____

Your Address: _____ City: _____ State: _____ Zip: _____

Main Phone: ( ) _____ Work Phone: ( ) _____

Email Address: _____

Dermatologist/Physician: _____ Phone ( ) _____

Referred by: _____ Reason for visit: _____

1. How sensitive is your skin? ☐ Very ☐ Moderate ☐ MIld
2. What products do you presently use?
   ☐ Soap ☐ Cleanser ☐ Toner ☐ Scrub
   ☐ Mask ☐ Creams ☐ Sunscreen ☐ Other
3. Please list cosmetics and skincare you are currently using:
   _____
   _____
4. Are you now using (or used in the past):
   ☐ Azelex ☐ Differin ☐ Retin A ☐ Renova
   ☐ Tazarec ☐ Glycolic or alphahydroxy acids
   ☐ Metrogel
5. Are you/have you taken accutane? ☐ Y ☐ N
   If yes, please specify _____
6. Are you presently taking any medication? ☐ Y ☐ N
   If yes, please specify _____
   _____
7. Do you experience frequent blemishes ☐ Y ☐ N
8. Have you been in the sun or in a tanning bed in the last 24 hours? ☐ Y ☐ N
9. Any allergies to any foods, cosmetics, or drugs? ☐ Y ☐ N
   If yes, please list _____
10. Are you currently under a physician's care? ☐ Y ☐ N
    If yes, please specify _____
11. Are you currently undergoing chemotherapy or radiation? ☐ Y ☐ N
10. Do you ever have burning/itching on your skin? ☐ Y ☐ N
11. Do you experience redness/irritation often? ☐ Y ☐ N
14. Are you on a special diet? ☐ Y ☐ N
    If Yes, please specify _____
15. Do you consume enough water daily? ☐ Y ☐ N
16. Do you exercise? ☐ Y ☐ N
    If yes, how often? _____
17. Have you ever had a facial? ☐ Y ☐ N
    If yes, when was your last facial? _____
18. Do you give yourself a facial at home? ☐ Y ☐ N
    If yes, how often? _____
19. (If getting waxed) Do you have any open lesions in the desired wax area? ☐ Y ☐ N

Please circle any of the following that apply to you:

Y N Asthma
Y N Cardiac problems
Y N Eczema
Y N Epilepsy
Y N Diuretics/Diet Pills
Y N Headaches - Chronic
Y N Diabetes
Y N Hepatitis
Y N Herpes/Fever Blisters
Y N High Blood Pressure
Y N Hysterectomy
Y N Immune Disorders
Y N Lupus
Y N Pregnancy
Y N Metal Bone, pins, or plates
Y N Pacemaker
Y N Psychological Disorders
Y N Sinus Problems
Y N Skin diseases - other
Y N Urinary or kidney problems
Y N Cancer

Client Signature: _____ Date: _____