

## Client Information and Health History

Consultation forms may include private client information or details the client does not wish to be shared. Please keep these forms secure and with you at all times during the competition. All consultation forms must be returned to the Tech Chair at the end of the contest. They will be placed in a sealed envelope and shredded.

To provide you with the most appropriate treatment, completion of the following questionnaire will assist the esthetician. All information is confidential.

Client Name: \_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_ Are you between the ages of 18-40? Yes  No

Email Address:	Phone #
Emergency Contact Name:	Phone #

**Medical History:** Are you currently under the care of a medical or health care professional? Yes  No

History	Comments	
	Yes	No
<b>Medical</b>		
Pregnant/ Planning		
Pacemaker		
Metal Implants		
Diabetes		
Herpes Simplex		
Migraines		
Autoimmune		
Cancer current/ recovered		
Radiation in past 3month		
Chemotherapy in past 3month		
Epilepsy		
Blood Pressure Issues		
Circulatory Disorders		
Varicose Veins		
Heart Conditions		
Embolism/Thrombosis		
Bruise Easily		
Edema		
Undiagnosed Swelling		
Loss of Tactile Sensation		
Arthritis /Osteoporosis		
Broken Bones/Strains		
Recent Surgery		
Mobility Issues		
Anxiety/Depression		
Claustrophobia		
Vertigo		
Asthma		
Thyroid Issues		
Gynecological Issues		

Menopausal Symptoms			
Digestive Disorders			
Hepatitis			
Skin Disorders			
<b>Allergies</b>			
	<b>Yes</b>	<b>No</b>	
Sun Reaction			
Medication			
Environmental			
Food			
Latex			
Aspirin			
Cosmetic Ingredients			
Other not mentioned			
<b>Nutrition</b>			
Do you have a regular eating schedule?			
Do you follow a balanced diet?			
Do you add additional salt or sugar			
Do you eat Fast Food?			
Daily water consumption			
Daily caffeine consumption			
<b>Lifestyle</b>			
Stress levels	1	2	3 4 5 6 7 8 9 10
Sleep Pattern	Good	Poor	Restless # Hours of uninterrupted sleep
Physical Activity Level	Walk	Swim	Cardio Resistance Training Team Sport Sedentary
<b>Skin Specifics</b>			
	<b>Yes</b>	<b>No</b>	
Recent microblading			Date: Comments:
Recent permanent makeup			Date: Comments:
Recent Laser			Date: Comments:
Hair Removal			Date: Comments:
Botox			Date: Comments:
Fillers			Date: Comments:
Chemical Peel			Date: Comments:
Sun/tanning bed exposure			Date: Comments:

I certify that the information I have provided is current and correct. I am aware that it is my responsibility to inform the esthetician of any changes to medications or medical conditions. I understand the treatment procedures and any possible reactions that could occur. I hereby give my consent to receive the treatment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

