Columbine
Massage Therapy & Day Spa

Client Info Sheet

Please print and fill out in detail
Today's date: ____/_____/2009

Client Information

Full Name

Mailing Address

City **State** **Zip**

Phone 1 **Phone 2**

Email Address

Gender
[ ] M [ ] F

Date of Birth:
_____/_____/_____

How did you hear about us?

[ ] Friend/Spouse Name:_____

[ ] Radio Station :_____ [ ] Mail Coupon

[ ] Gift Certificate [ ] Phone Book

[ ] ColumbineDaySpa.com [ ] Internet

[ ] Other: _____ [ ] Newspaper

Conditions:

Arthritis	[ ] When _____
Asthma	[ ] When _____
Autoimmune Disorder	[ ] When _____
Back Pain	[ ] When _____
Blood Press. [ ] Hi [ ] Lo	[ ] When _____
Blood Sugar [ ] Hi [ ] Lo	[ ] When _____
Bruise Easily	[ ] When _____
Bursitis	[ ] When _____
Cancer	[ ] When _____
Chest Pain / Tightness	[ ] When _____
Diabetes	[ ] When _____
Fainting Spells	[ ] When _____
Fibromyalgia	[ ] When _____
Fractures	[ ] When _____
Heart Condition	[ ] When _____
Headaches/Migraines	[ ] When _____
Hip/Leg Pain	[ ] When _____
Jaw	[ ] When _____
Neck Pain	[ ] When _____
Sciatica	[ ] When _____
Scoliosis	[ ] When _____
Shoulder/Arm Pain	[ ] When _____
Skin Lesions/ Inflammation	[ ] When _____
Smoker	[ ] When _____
Surgery	[ ] When _____

Are You Pregnant? [ ] No [ ] Yes # Months_____

List All Allergies: _____

_____

List any Medical Conditions:_____

_____

NAME _____

ADDRESS _____

CITY & ZIP_____

PHONE _____

DATE OF 1ST VISIT _____

AGE_____

REFERRED BY _____

General Health Record

Are you a sun lover? Yes [ ] No [ ]
Are you pregnant? Yes [ ] No [ ]
Any menopause problems? Yes [ ] No [ ]
Are you: *Claustrophobic? Yes [ ] No [ ]
*Asthmatic? Yes [ ] No [ ]
Any heart problems? Yes [ ] No [ ]
Do you wear contacts? Yes [ ] No [ ]
Any skin problems?_____ Yes [ ] No [ ]
Any allergies? _____ Yes [ ] No [ ]
Any skin cancer? _____ Yes [ ] No [ ]
Any recent surgery?_____ Yes [ ] No [ ]
Any plastic surgery?_____ Yes [ ] No [ ]
Are you currently taking any medication? Yes [ ] No [ ]

Do you use Retin A? Yes [ ] No [ ]
* For what purpose? _____
Have you ever used Accutane? Yes [ ] No [ ]
If yes, When? _____
Do you use Glycolic Acid products? Yes [ ] No [ ]
Have you ever had an Acid Peel? Yes [ ] No [ ]

Have you been exposed to the sun or sun beds recently? Yes [ ] No [ ]
If yes, explain_____
On the Pill? Yes [ ] No [ ] If yes, since when? _____
Hormones? Yes [ ] No [ ] Herpes/Cold Sores Yes [ ] No [ ]
Epileptic? Yes [ ] No [ ] Hemophiliac? Yes [ ] No [ ]
Diabetic? Yes [ ] No [ ] Arthritic? Yes [ ] No [ ]
Hepatitis? Yes [ ] No [ ] Pacemaker? Yes [ ] No [ ]
Do you smoke? Yes [ ] No [ ]
Any pins, metallic or cosmetic implants? Yes [ ] No [ ]
If yes, explain _____
If yes, explain _____
If yes, explain _____
If yes, explain _____
If yes, explain _____
Do you have any history of acne or periodic breakouts? Yes [ ] No [ ]
Have you recently had Botox, Laser resurfacing? Yes [ ] No [ ]
]Do you use depilatories or wax on your face? Yes [ ] No [ ]

General Skin Care Information

How do you cleanse your face? [ ] Soap [ ] Cleanser [ ] Other Please specify brand
_____

Do you use any home treatment products? Yes [ ] No [ ] If yes, what brand? _____

What is the purpose of this visit?
_____

What kind of improvement would you like to see on your skin?

Skin Analysis

Skin Texture		[ ] Fine	[ ] Medium thickness	[ ] Thick	[ ] Very Thick
Complexion Color	[ ] Pale	[ ] Healthy	[ ] Muddy	[ ] Waxy	
		[ ] Olive	[ ] Suntanned	[ ] Ebony	
Dehydrated		[ ] Superficially	[ ] Deeply		
Active Sebaceous Glands		[ ] Oily	[ ] Asphyxiated	[ ] Seborrheic	[ ] Comedogenic
		[ ] Dilated Pored	[ ] Acne	[ ] Cystic Acne	
Insufficient Gland Secretion		[ ] Dry	[ ] Alipoid		
Skin Type		[ ] Normal Skin	[ ] Partially Oily		
Circulation Problems		[ ] Couperose	[ ] Erythrose	[ ] Rosacea	
*Precise area		[ ] Nose	[ ] Cheeks	[ ] Chin	[ ] Forehead
		[ ] Entire Face			
Muscle Tone		[ ] Good Face Contour	[ ] Medium Lack of Tone		[ ] Fallen
Aging Signs		[ ] Deep Expression Lines	[ ] Crow's Feet		[ ] Fine Lines All over Face
		[ ] Crepeness Around Eyes			[ ] Falling Eyelids
Other Problems	SCARS	[ ] Light	[ ] Medium	[ ] Deep	
	PIGMENTATION	[ ] Light Freckles	[ ] Dark & Heavy Freckles	[ ] Pregnancy Mask	
		[ ] Birthmarks	[ ] Brown Patches	[ ] Photosensitivity	
		[ ] Double Chin	[ ] Deteriorated Neck	[ ] Milium	[ ] Sensitivity around Mouth

Skin Care Record

Date	Type of Treatment	Aesthetician

Samples

Date	Samples Given

	Samples Given

Recommended Home

Date	Day Care

	Day Care

Date	Type of Treatment	Aesthetician