



# la vita bella day spa

## Massage & Facial Information

Name \_\_\_\_\_ Phone (h) \_\_\_\_\_ (m) \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ Birthdate \_\_\_\_\_

How did you discover us? \_\_\_\_\_

1) In the last year, have you been under a dermatologist or physician's care? Yes \_\_\_\_\_ No \_\_\_\_\_

2) In the last year, have you undergone any surgery? Yes \_\_\_\_\_ If 'yes', please explain \_\_\_\_\_ No \_\_\_\_\_

3) Please list any health problems: \_\_\_\_\_

4) Have you had any dental x-rays in the last 6 months? Yes \_\_\_\_\_ No \_\_\_\_\_

5) List all medications, supplements, vitamins, diuretics that you regularly take: \_\_\_\_\_

6) Do you have any special skin problems concerning your face or body? Yes \_\_\_\_\_ No \_\_\_\_\_

If 'yes', please explain: \_\_\_\_\_

7) Do you use Retin A, Renova, Adapalene or any other prescribed skin products? Yes \_\_\_\_\_ No \_\_\_\_\_

If 'yes', please explain: \_\_\_\_\_

8) Do you burn easily in moderate sunlight? Yes \_\_\_\_\_ No \_\_\_\_\_

9) Do you have a tendency to redness? Yes \_\_\_\_\_ NO \_\_\_\_\_

10) Do you ever experience a burning, itching sensation to your skin? Yes \_\_\_\_\_ No \_\_\_\_\_

11) Do you ever experience any of the following conditions to your skin:

Flakiness \_\_\_\_\_ Tightness \_\_\_\_\_ Obvious Dryness \_\_\_\_\_

12) Are you currently using any products containing the following:

Glycolic Acid \_\_\_\_\_ Lactic Acid \_\_\_\_\_ Exfoliating Scrubs \_\_\_\_\_ Vit A derivatives \_\_\_\_\_

13) Do you experience an oily shine? Yes \_\_\_\_\_ No \_\_\_\_\_

14) Do you experience skin breakouts? Yes \_\_\_\_\_ No \_\_\_\_\_

15) In the last month, have you had any chemical peels, microdermabrasions or resurfacing treatments?

Yes \_\_\_\_\_ No \_\_\_\_\_

16) Do you have allergies to any of the following:

Seaweed \_\_\_\_\_ Iodine \_\_\_\_\_ Hydroxy Acids \_\_\_\_\_ Fragrance \_\_\_\_\_ Sunscreens \_\_\_\_\_

Other \_\_\_\_\_

17) Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

18) Do you wear contact lenses? Yes \_\_\_\_\_ No \_\_\_\_\_

19) Do you have any metal implants, a pacemaker or body piercings? Yes \_\_\_\_\_ No \_\_\_\_\_

20) Have you ever experienced claustrophobia? Yes \_\_\_\_\_ No \_\_\_\_\_

21) Are you pregnant or lactating? Yes \_\_\_\_\_ No \_\_\_\_\_

22) Are you a diabetic? Yes \_\_\_\_\_ No \_\_\_\_\_

23) Do you have high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_

Consent: I, \_\_\_\_\_, confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

I understand that 'la vita bella day spa' is not responsible for any problems that may occur during any treatment if using any topical or oral, prescribed or over the counter medications.

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