TheGlobalBeautyGroup
Technology for Beautiful Business

BIO-THERAPEUTIC

Consultation Form

Name:_____ Date:_____

By completing this client profile, you will assist us (The Spa) in evaluating your skin condition. The information you provide will be used to determine what factors may be affecting your skin so that we may recommend the proper care.

Address:_____

How did you hear about us?:_____ Best Phone:_____

Email:_____ Date of Birth:_____ Age:_____

Emergency Contacts:

Option 1:_____ Phone:_____

Option 2:_____ Phone:_____

Health/Medical *(Please answer to best of your knowledge)*

Physician's name, address, and phone number:_____

Please list all medications that you take regularly. (*Include hormones, vitamins, etc):*_____

_____

Please tick any health conditions which you have had or are now experiencing:

- ☐ Cancer
- ☐ Thrombosis
- ☐ Recent Illness
- ☐ Multiple Sclerosis
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Pregnancy _____
- ☐ Phlebitis
- ☐ Light/Photo Sensitivity
- ☐ Metal Implants/Screws
- ☐ Asthma
- ☐ Lack of Normal Skin Sensation
- ☐ Epilepsy
- ☐ Hemophilia
- ☐ Heart Problems
- ☐ Hormonal Disorders
- ☐ Thyroid Disorders
- ☐ Recent Surgery
- ☐ Seizures
- ☐ HIV
- ☐ Pacemaker
- ☐ Claustrophobia
- ☐ Muscular Conditions
- ☐ Whiplash
- ☐ Lupus
- ☐ Hepatitis
- ☐ Alcoholism
- ☐ Smoking
- ☐ High/Low Blood Pressure
- ☐ Seizures

Allergies:_____

_____

Is there anything else you would like us to be aware of: _____

_____

Have you ever undergone treatment from a Dermatologist? ☐ Yes ☐ No

If yes, when?_____

What type of condition?_____

Any negative side effects?_____

Have you ever undergone treatment from an Aesthetician? ☐ Yes ☐ No

If yes, when?_____

What type of condition?_____

Any negative side effects?_____

Within the last month, have you taken or used any of the following?

☐ Retin A ☐ Antibiotics ☐ Diuretics ☐ Accutane ☐ Oral Contraceptives ☐ Laxatives

Have you ever undergone plastic surgery? ☐ Yes ☐ No

If yes, when?_____

Where on your body?_____

What information can you provide about the procedure?_____

_____

Nutrition/Diet

Check the types of fluids that you consume daily and indicate the amount per day:

☐ Water_____ ☐ Juices_____ ☐ Tea_____

☐ Coffee_____ ☐ Alcohol_____ ☐ Sodas_____

Home Skin Care Regimen

Describe (using product brand names) how you are presently caring for your skin:

	AM	PM		AM	PM
Cleanser:			Exfoliant:		
Toner:			Serum:		
Moisturizer:			SPF Sunscreen:		
Make-Up			Other:		

How many hours do you sleep per night?_____

How often do you exercise?_____

On a Scale from 1 (low) to 10 (high) how would rate your stress?_____

How much sun exposure have you had?_____

What are your Goals and Expectations?

What is your specific concern about your skin?_____

_____

How long have you noticed your condition?_____

Is this an ongoing or temporary condition?_____

What specific improvements do you wish to see?_____

_____

In what time frame do you expect to reach your goals?_____

Have you ever received a salon/spa skin care treatment?_____

What were the results?_____

Previous aesthetic treatments, please check all that apply

☐ Botox Date:	☐ Dermal Fillers: Restylane/Juvaderm/Sculptra Date:	☐ Facials Date:	☐ Laser Treatments Date:
☐ IPL/Photo rejuvenation Date:	☐ Chemical Peels Date:	☐ Microdermabrasion Date:	☐ Microcurrent Date:
☐ LED Light Therapy Date:	☐ Oxygen Infusion Treatment Date:	☐ Facial Waxing: Date:	☐ Other: Date:

Client Liability Release

Client Liability Release and Agreement Not to Sue

Caution: Microcurrent or vacuum massage will not be performed if any of the following conditions exist: Any severe health conditions, or any of the following contraindications: Cancer, Epilepsy, History of Seizures, Pacemaker, Pregnancy, HIV, Thrombosis or Phlebitis or conditions that are unknown. A physician must be consulted.

Caution: Microdermabrasion applications will not be performed if any of the following conditions exist: Any severe health conditions or any of the following contraindications: any contagious disease, any drug causing sun sensitivity (Tetracycline), any drug or application causing thinning of skin (Retin-A or Accutane), blood transmitted diseases (HIV, Hepatitis, Herpes), Hemophilia, or conditions that are unknown. A physician must be consulted.

Caution: LED light rejuvenation applications will not be performed if any of the following conditions exist: Any severe health conditions or any of the following contraindications: Hypersensitivity to light or "photo allergy," tendency toward photo-toxic reactions, taking of photo-sensitizing or photo-toxic medication, Cancer, Epilepsy, History of Seizures, Lupus, Pregnancy, or conditions that are unknown. A physician must be consulted.

I certify that the above statements are true and correct, and that I, ..., having been advised and fully informed by ..... of The Spa concerning the nature of the process to be performed by them, the risks and benefits of the process, and the risks and benefits of not having the process performed hereby authorize and direct The Spa to perform such process and perform such services as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that:

(1) I have read, understand and fully agree to the foregoing;

(2) Understand the caution and contraindications for each process and service proposed;

(3) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire AND;

(4) I hereby give my consent and authorization to the process described and knowingly and voluntarily agree not to sue Bio-Therapeutic Anti-Aging Skin Spa Inc. (The Spa), its agents, officers, and/or employees and, further, to release, hold harmless and indemnify, for myself and my heirs or assigns, The Spa, its agents, officers, and/or employees for and from any claims for personal or bodily injury that I may have or in the future may discover, arising from or in connection with the described application, process or service, including but not limited to The Spa's errors, omissions, or negligence.

Client Full Printed Name_____ Date_____

Client Signature_____ Date_____

Witness Full Printed Name_____ Date_____

Witness Signature_____ Date_____

CONDITION	Yes	No
Cancer		
Pregnancy		
Epilepsy		
Seizures		
Lupus		
Diabetes		
Phlebitis/Thrombosis		
HIV / Herpes / Hepatitis (indicate which)		
Medications		
Retin A, AHA, Tetracycline, Accutane		
Pacemaker		
Other		
STAFF SIGNATURE	DATE	