

# The Medical Spa

@ GMG

## Consultation

Name \_\_\_\_\_ Therapist: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mail Address \_\_\_\_\_

Telephone Home( ) \_\_\_\_\_ Work( ) \_\_\_\_\_

Birthday \_\_\_\_\_ Under 21 21-30 31-40 41-50 51-60 60+

How did you hear about us? \_\_\_\_\_

## Your Health

1. Within the last year, have you been under a dermatologist's or other physician's care? Yes No
2. Within the last nine months, have you undergone any surgery? Yes No
3. Have you had any health problems in the past or present? Yes No  
If yes, please specify \_\_\_\_\_
4. List any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly.  
\_\_\_\_\_
5. Do you Smoke? Yes No
6. Do you exercise regularly? Yes No
7. Do you follow a restricted diet? Yes No
8. Do you wear contact lenses? Yes No
9. Do you have metal implants, a pacemaker or body piercings? Yes No
10. Rate your level of stress on a scale of 1 to 4(1=low stress,4=high stress) \_\_\_\_\_

## Your Skin

11. Do you have any special skin problems pertaining to your face or body? Yes No  
If yes, please specify \_\_\_\_\_
12. What skin products are you currently using?  
Face: soap cleanser toner moisturizer masque exfoliator eye products  
Body: soap shower gel scrubs oil body moisturizer depilatory products self-tanners

## Exfoliation history

13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?  
Yes No *In the last month?* Yes No
14. Do you use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products?  
Yes No *In the last 3 months?* Yes No
15. Are you currently using any products that contain the following ingredients?  
Glycolic acid Lactic Acid Any exfoliating scrubs Any hydroxy acid product Vitamin A derivatives (i.e., retinol)

## Moisture hydration

16. How much plain water do you consume daily? \_\_\_\_\_
17. How many alcoholic beverages do you consume weekly? \_\_\_\_\_
18. Do you ever experience these conditions on your skin? flakiness tightness obvious dryness
19. What spf sunscreen do you use on your face? \_\_\_\_\_ Body? \_\_\_\_\_
20. Do you sunbathe or use tanning beds? Yes No

## Capillary activity

21. Do you burn easily in moderate sunlight? Yes No
22. Do you blush easily when nervous? Yes No
23. Do you have a tendency to redness? Yes No
24. Do you suffer from sinus problems? Yes No

## Oil secretion

25. Do you ever experience oily shine during the day? Yes No Occasionally
26. Do you ever experience skin breakouts? Yes No Occasionally

### ***Nerve activity***

27. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) Yes No
28. Do you ever experience a burning, itching sensation on your skin? Yes No
29. What is your pain threshold? Low Medium High
30. Have you ever experienced claustrophobia? Yes No
31. What type of massage pressure do you prefer? Light Medium Firm

32. Have you ever had a reaction to any of the following?

- Cosmetics Medicine Iodine Pollen Food Hydroxy acids Animals Fragrances  
Sunscreens Other \_\_\_\_\_

### ***Female clients only***

33. Are you taking oral contraceptives? Yes No
34. Are you pregnant or trying to become pregnant? Yes No
35. Are you lactating? Yes No

### ***Male clients only***

36. What is your current shaving system? Electric Blade
37. Do you experience irritation from shaving? Yes No
38. Do you experience ingrown hairs? Yes No

### ***Questions to discuss every visit***

39. Are you currently having or due for your menstrual period? Yes No
40. Have you started any new medication since your last visit? Yes No
41. Have you had any recent dental x-rays? Yes No
42. What are your skin care goals? \_\_\_\_\_

I confirm (to the best of my knowledge) that the answers I have given are correct and I have not withheld any information that may be relevant to my treatment.

Client signature \_\_\_\_\_

Date \_\_\_\_\_