



Medical History Form

Name _____ Home Number _____ DOB _____
 Address _____ Cell Number _____ Sex _____
 City _____ State _____ Zip _____ e-mail _____
 How did you hear about us _____ Profession _____
 Emergency Contact _____ Contact # _____

General

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Skin/Nail Infections |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Aroma Sensitive | <input type="checkbox"/> Cold Sores/Herpes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Tissue Disorders |
| <input type="checkbox"/> Hot/Cold Sensitive | <input type="checkbox"/> Smoker | <input type="checkbox"/> Alcohol/Drugs |
| <input type="checkbox"/> Diet/Nutritional Needs | <input type="checkbox"/> Exercise | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Current Medications | <input type="checkbox"/> Addictive Disorders | <input type="checkbox"/> Other |

Endocrine System

- Thyroid/Gland
- Diabetes
- Steroid/Hormone Therapy
- Melasma

Urinary System

- Kidney Disease
- Frequent Urination
- Blood in Urine
- Kidney Stones

Neurological

- Headaches
- Seizures
- Memory Disorders
- Numbness/Tingling
- Limp/Body weakness

Musculoskeletal System

- Joint/Stiffness
- Fibromyositis/Myalgia
- Neck Pain
- Lower Back Pain
- Extremity Pain

CardioVascular

- Heart Disease
- Hi/Low Blood Pressure
- Dizziness/Fainting
- Bruise Easily
- Color Change

Gastrointestinal

- Colitis/IBS
- Stomach Ulcers
- Liver Disorders
- Gallbladder Disorder
- Constipation

Dermatological System

- | | | |
|---|---|---|
| <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Keloid/Thick Scars |
| <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Grafted Skin | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Birthmarks | <input type="checkbox"/> Skin Reactions | |

Female Patients

- Pregnant
- Menopause
- Abnormal Menses

Male Patients

- Testosterone Supplements
- Anabolic Enhancers
- Prostate disorders

Allergies (Please List)

Please list any and all medications or herbal supplements you are taking at this time

Previous Treatments

Dermatological Surgery Cosmetic/Laser Peels Body Contouring
 Acutaine/Retin-A Dermabrasion Plastic Surgery
When /Strength Permanent Make-up

Fitzpatrick Skin Typing: Please select the description that best explains the way your skin responds to the sun after 15 minutes of unprotected exposure:

Always burn (Type 1) Always burns, uneven tan & freckles (Type2)
 Sometimes burns, always tans (Type 3) Rarely burns, always tans (Type 4)
 Never burns, deeper tan (Type 5) Never burns-African American (Type 6)

Ethnic Heritage _____ Natural Hair Color _____
Date of last tanner _____ Areas Used _____

Please list any area waxed that will be treated _____
Date of recent sun tanning(15 minutes or more) _____

Check the following treatments that you are interested in either today or at a later date

Cellulite Reduction Weight Loss/Management Hormone Therapy
 Fat Reduction Spider Vein Treatment Facials
 Microdermabrasion Massage Dermal Wrinkle Fillers
 Botox Liquid Facelift Waxing/Hair Removal

Check the following conditions that you would like to correct

Excess Weight Sunspots Aging Dryness
 Irritated Skin Rosacea Acne Melasma
 Rough Skin texture Enlarged pores Wrinkles Cellulite

Other _____

Do you consider yourself to be?

Low Stress Medium Stress High Stress

Any Specifics? _____

By signing below, I acknowledge that the information disclosed in the health history form is accurate and complete and I have revealed all information to the best of my knowledge. I understand that this information will be kept confidential, viewed only by the Medical Director and any Chastain Wellness Studio personnel that may be administering my care. I further understand that any changes in my health history should be documented and up dated by me immediately. I will advise Chastain Wellness Studio of any changes in the health or medical condition immediately. I will follow all pre and post care instructions for my treatments.

Signature _____

Date _____

Photograph consent and Release Form: I, undersigned, do hereby agree to the following. I am allowing Chastain Wellness Studio Staff members to take photos of my treatment and/or treatment areas to be used for the purpose of monitoring my progress and clinical chart documentation, education and/or advertising. At my request, my identity will remain anonymous _____ (please initial)

Signature _____

Date _____