NEW CLIENT HISTORY FORM

First Name_____ Date_____

Last Name_____ DOB_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____

Email_____

Ethnic background_____ Occupation_____

What brings you to Royalty Wellness Spa?_____

How did you hear about us?_____

MEDICAL HISTORY

Are you allergic to latex, any medications, any herbal/natural supplements? YES NO

Please list:_____

Do you have any chronic medical problems? YES NO

Please list:_____

Have you had any recent changes in your medical history? YES NO

Please list any current and past surgeries:_____

_____

Are you taking any daily anticoagulants (including Aspirin, Motrin, or Advil)? YES NO

Are you a smoker? YES NO

Do you have a history of cold sores/fever blister? YES NO

If so, when was you last outbreak?_____

Do you have a history of keloid scarring? YES NO

Have you ever been treated with injection, a laser, microdermabrasion, or chemical peel? YES NO

If so, please list:_____

Do you have permanent makeup or tattoos? YES NO

If so, please list?_____

Women Only

Are you or could you be pregnant? YES NO

Are you currently breast feeding? YES NO

Additional information you would like us to know_____

_____

Client Signature_____ Date_____

Witness_____ Date_____

Do you take any prescription or over the counter medications? YES NO

Please List:_____

YES	NO	Do you have any of the following conditions? (current or past)	Resolved	Controlled	Uncontrolled
		Medication allergies (specify)			
		Food allergies (specify)			
		Autoimmune Disorder (Lupus, RA, psoriasis)			
		HIV or AIDS			
		Hypertension/Hypotension			
		Heart Condition (specify)			
		Diabetes Type 1 or 2			
		Staph infection			
		Asthma			
		Lung disorder (Emphysema, Chronic Bronchitis, COPD)			
		Hepatitis (specify)			
		Kidney Disease (specify)			
		Skin Caner (specify type and location)			
		Cancer (specify)			
		Thyroid disease (specify)			
		Shingles (specify location and last episode)			
		Neuromuscular/Neurological Disorder (specify)			
		Slow Wound Healing			
		Sensitive skin (specify)			
		Electrical Implants (specify)			
		Previous Complications with cosmetic injections or laser treatments? (specify)			
		Any other Health Conditions not listed above (specify)			

The above health questionnaire is accurate. I will disclose any changes to my health at future visits

Print Name_____ Signature_____

Date_____ Practitioner Signature_____