**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthday:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What would you most like to improve in your skin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When was your last skin care service/wax/body treatment? Date:\_\_\_\_\_\_\_\_\_\_\_For:\_\_\_\_\_\_\_\_\_Where:\_\_\_\_\_\_\_\_**

**Describe your skin, please circle:** Normal - Dry - Oily - Acne Prone - Combination - Mature - Sensitive

**PLEASE DESCRIBE CURRENT SKIN CARE REGIMEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Health Related Questions:** | **Yes or No** |
| **Are you pregnant or trying to get pregnant?** |  |
| **Are you under the care of a Dermatologist or Cosmetic Surgeon?** |  |
| **Have you had Botox or Fillers?**  Most recent application:\_\_\_/\_\_\_/\_\_\_ |  |
| **Have you had Chemical or Laser Resurfacing?**  Most recent application:\_\_\_/\_\_\_/\_\_\_ |  |
| **Do you have eyelash extensions/ wear contact lenses?** |  |
| **Do you have a Pacemaker or Metal Implants?** |  |
| **Have you ever experienced or are experiencing any of these health issues?**  **Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Please circle:**  Cancer  Epilepsy  Conjunctivitis  Claustrophobia  Diabetes  Eczema  High/Low Blood Pressure  Hormone Imbalance  Cold Sores  Sunburn |
| **Please list all allergies or skin reactions to any products, medications you have experienced in the past:** |  |
| **Are you using any Oral/Topical Medications for skin condition?** |  |
| **Are you using Retin-A or Retinol?** |  |

**How did you hear of Solstice Day Spa?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I attest the above information is accurate.**

**Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**