ENDLESSBEAUTY
SKIN CARE
WHERE HEALTH AND BEAUTY BECOME ONE

Health Questionnaire

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (___)_____ Email: _____

Who referred you/How did you find us? _____

Medical: Are you currently or within the last year under any Doctors care? ☐ No ☐ Yes
If Yes, Please Explain:_____
Health Problems: ☐ Diabetes ☐ Thyroid ☐ Heart ☐ Cancer ☐ Epilepsy ☐ High/Low Blood Pressure ☐ HIV ☐ Other
_____
Have you undergone surgery recently? ☐ No ☐ Yes _____
Do you have any metal implants? ☐ No ☐ Yes Please list: _____
Medications/Vitamins/Supplements? Please list all & why:_____
_____
Do you smoke? ☐ No ☐ Yes
Do you exercise regularly? ☐ No ☐ Yes
What is your daily consumption of: Water _____(oz.) Coffee/Tea _____(oz.) Alcohol _____(oz.) Soft Drinks _____(oz)

Areas of concern for skin care: _____
What water temperature do you cleanse with? ☐ Cold ☐ Warm ☐ Hot
Do you ever experience skin break-outs? ☐ No ☐ Yes
Blush easily? ☐ No ☐ Yes Sunburn easily? ☐ No ☐ Yes Redness Tendency? ☐ No ☐ Yes

Massage Preference? ☐ Firm ☐ Med ☐ Light
Pain Threshold? ☐ High ☐ Med ☐ Low

Female Clients Only: Are you pregnant or trying to become pregnant? ☐ No ☐ Yes
Are you due for your menstrual period within the next week? ☐ No ☐ Yes

HAVE YOU EVER HAD AN ALLERGIC REACTION? (Including foods, medications, etc..)

☐ **No** ☐ **Yes** (if yes please explain) _____

Signature: _____ Date: _____

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