



Client Information & Health History

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell#: _____ Work#: _____ Home#: _____

Email: _____

Preferred method of contact: email ___ cell# ___ work# ___ home# ___

Date of Birth: _____ Occupation: _____

How did you hear about us? _____

Do you have any medical conditions? _____

Please list any current medications, vitamins, or supplements:

Name	Dosage	Frequency

Do you take Motrin, Advil, daily Aspirin, or other anticoagulants? _____

Please list any allergies to latex, medications, food, or other substance? _____

Please list all current/past surgeries or surgical procedures: _____

Do you smoke? _____ Are you pregnant? _____



Name: _____ Date: _____

Please answer ALL of the following questions:

	Yes	No	If yes, please explain
Pacemaker			
Cancer			
Tumor			
Epilepsy			
Heart Condition			
High Blood Pressure			
Diabetes			
Inflammation/Infection			
Autoimmune Disorder			
Multiple Sclerosis			
Muscular condition			
Varicose veins			
Allergy—Rubber/Metals			
Lack of normal skin sensation			
Skin disease			
Thrombosis/Phlebitis			
Metal Implants/Screws			
Prosthesis/Silicone			
Cold sores, fever blisters, Herpes I or II			

Any other medical conditions that are not listed? _____

Do you have a history of keloid scarring? _____

What is your ethnicity? [i.e., German, Irish, etc. to determine skin type and treatment]

Natural hair color: _____ Natural eye color: _____



Name: _____ Date: _____

What skincare products do you use? _____

When did you use these last? _____

Do you use: Retin-A? ____ Glycolic Acid? ____ Anticoagulants, Aspirin, Motrin, Advil? ____

Have you used Accutane within the past year? _____

Do you have any permanent make-up or tattoos? _____

Have you ever had any skin treatments such as Lasers, microdermabrasion, chemical peels, or injections?

Treatment	Date

General appearance or skin concerns [please check all that apply]:

<input type="checkbox"/> Fine lines and wrinkles	<input type="checkbox"/> Facial redness
<input type="checkbox"/> Facial folds—around mouth and/or nose	<input type="checkbox"/> Dark circle under eyes
<input type="checkbox"/> Rough texture of skin	<input type="checkbox"/> Thin lips
<input type="checkbox"/> Tired looking skin	<input type="checkbox"/> Facial acne
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Body acne
<input type="checkbox"/> Oily skin	<input type="checkbox"/> Facial or leg veins
<input type="checkbox"/> Sagging skin	<input type="checkbox"/> Thinning lashes
<input type="checkbox"/> Uneven skin tone	<input type="checkbox"/> Neck laxity
<input type="checkbox"/> Brown spots/hyperpigmentation/melasma	<input type="checkbox"/> Large pores

Please rank your top five concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Comments:



Name: _____ Date: _____

Products or treatments of interest to you [please check all that apply]:

<input type="checkbox"/>	Skin care advice	<input type="checkbox"/>	Depigmentation
<input type="checkbox"/>	Skin care products	<input type="checkbox"/>	Botox® Cosmetic
<input type="checkbox"/>	Removing spider veins	<input type="checkbox"/>	Dermal Fillers
<input type="checkbox"/>	Eye treatments	<input type="checkbox"/>	Lightening cream
<input type="checkbox"/>	Peels	<input type="checkbox"/>	Latisse®

When I look at my face in the mirror, I believe I look younger than, the same, or older than my true age? _____

When I look in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles and/or skin laxity? _____

Consent to Photograph:

The undersigned hereby authorized Agave Aesthetics, LLC to photograph and agrees that the negatives, print, or digital images prepared there from may be used for the purposes checked below:

- Medical Record
- Education and/or Demonstration
- Publication
- Other specified

I have read and understand this agreement:

Client Signature: _____ **Date:** _____

Cancellations:

Your scheduled appointment is reserved exclusively for you. Should you need to cancel or reschedule your appointment, please notify us at least 24 hours ahead. We do require a credit card be kept on file for spa appointments, and your card will be charged a fee of \$50 for any late cancellations or no-shows.

Client Signature: _____ **Date:** _____

Client Rights & Responsibilities



We are committed to serving you with compassion, care, and respect. As one of our valued clients, you are entitled to the following:

YOU HAVE THE RIGHT:

- To be treated with dignity and respect
- To know the names and professional status of the person(s) serving you
- To privacy and confidentiality
- To receive accurate information about your health-related concerns
- To know the effectiveness and possible side effects of all forms of treatment
- To participate in choosing the form of treatment best suited to your skin
- To receive education and counseling about treatments
- To review your medical record with your clinician
- To amend your medical record
- To receive any information about potential services or related costs

YOU HAVE THE RESPONSIBILITY:

- To seek medical attention promptly
- To be honest about your medical history, as well as, your sun exposure
- To ask questions about anything you do not understand
- To follow health advice and instructions
- To report any significant changes in your health or medications
- To respect the clinical policies, and provide useful feedback regarding our service and policies
- To attend scheduled appointments, or cancel at least 24 hours in advance

I authorize, Agave Aesthetics, LLC, to perform the treatments or procedures recommended. I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of any treatments or procedures.

I fully understand that it is impossible to make a guarantee regarding the outcome of any medical treatments or procedures.

I understand I am financially responsible for all amounts due at the time services are rendered, and for any appointment I fail to attend without at least 24 hours notice.

I also authorize the release of information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of his/her recommendations.

Client Signature _____ **Date** _____

Reviewed By _____ **Date** _____