Integrated Wellness

Rejuvenation Intake Form

PLEASE PRINT Today's Date_____

FIRST NAME _____ LAST NAME_____

Date of Birth ____/____/_____ Goals _____

Address _____

City _____ ZipCode. _____

Phone: Home _____ Mobile _____ Work _____

E-Mail _____ How did you hear about us?_____

1. What is the reason for your visit today?

_____

2. What special areas of concern do you have?

_____

__Acne scarring __Acne __Age Spots __Fine lines & wrinkles __Sun damage __Scars
__Abdominal __Stretch Marks __Breast __Thighs/Buttocks __Upper arms __Cellulite
__Arms __Upper Thighs __Other _____

3. Do you __Sun bathe? __Use a tanning bed?
How often? _____

4. Have you ever had
__Microdermabrasion __Cosmetic Surgery? If yes how long ago?_____
__Laser Hair Removal __Cosmetic Fillers? __Restylane __Collagen Injections
__Botox __Fillers __Chemical or natural peels
__Body treatments? _____

5. Do you bruise easily? __Yes __No

6. Do you get cold sores/blisters (Herpes Zoster/Shingles)?
__Yes __No

7. What medications/hormone replacement/vitamins do you presently take?
_____
_____

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8. Have you ever used __Accutane® __Retin-A® __Renova® __Topical Antibiotics __Hydroquinone

9. Any personal or family history of cancer?
__Yes __No What kind? _____

10. Are you under a physician's care at the moment?
__Yes __No Provide detail _____

11. How would you describe your overall health?
__Excellent __Good __Fair __Poor

12. Have you ever had a reaction to
__Metals __Medication __Food __Cosmetics __Fragrance __Air borne particles __Other allergies?
Explain _____

13. FOR MEN:
Do you experience breakout? __Yes __No
Do you have ingrown hair? __Yes __No

14. For women:
Taking hormones or birth control? __Yes __No
Are you pregnant or trying to get pregnant? __Yes __No

15. Have you had any of the following, past or present?

Acne __Yes __No When _____
Arthritis or Bursitis __Yes __No
Breast Implant __Yes __No
Cholesterol __Yes __Normal
Diabetes __Yes __No
Eczema __Yes __No Where _____
Hay Fever __Yes __No
Heart __Yes __No What_____
Hirsutism __Yes __No
Infections __Yes __No
Metal Implants __Yes __No
Phlebitis __Yes __No
Serious Injury __Yes __No What _____
Varicose Veins __Yes __No
Do you wear contact lenses? __Yes __No
Head injury? __Yes __No When_____
Arthritis __Yes __No Where_____

Allergies __Yes __No
Blood Pressure __Yes __No
Cataracts __Yes __No
Claustrophobic __Yes __No
Diarrhea/constipation __Yes __No
Epilepsy __Yes __No
Headaches __Yes __No How often_____
Hepatitis __Yes __No
Hormone Imbalance __Yes __No
Lupus __Yes __No
Pace Maker __Yes __No
Psoriasis or Vitaligo
Thyroid __Yes __No
Do you smoke? __Yes __No
Broken bones? __Yes __No Where_____
Leg and/or foot pain? __Yes __No
Polio/palsy/paralysis? __Yes __No

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Is your stress level __High __Medium __Low
Do you normally sleep well? __Yes __No
Do you regularly exercise? __Yes __No
Food intolerances? __Yes __No
Do you follow any special diet? __Yes __No
Daily water intake? _____ glasses a day
Cups of caffeine-type beverage __1-3 cups __4 or more
Alcohol Drinks? __1glass __2 or more
Do you consume everyday __Fruit __Protein __Complex Carbohydrates __Vegetables & Salad

Disclosures:

I _____, do fully understand all the questions above and have answered them correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the practitioner will completely inform me of what to expect in the course of treatment, and will recommend adjustments to my regimen if deemed necessary. I have completely discussed my concerns and have had my questions answered. I also am aware that individual results are dependent upon my age, health condition, and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum results. In the event that I may have additional questions or concerns regarding my treatment, I will inform my practitioner immediately.

I release the therapist, and Integrated Wellness harmless from any liability that may result from this treatment.

_____ Date _____
Signature