

Essence of Eve Day Med Spa - Client Profile Information

We are required by the Texas Department of Licensing and Regulation as well as the Texas Department of Health to obtain certain health history information. Therefore, profiles are completed by all of our clients and patients. We may ask you to complete one of these periodically in the event we need to update our records. However, it is the client's/patient's responsibility to keep our staff informed of any changes to your health history. Thank you for your understanding in assisting us with your care.

First Name _____ Middle _____ Last _____

Date Profile Completed _____ / _____ / _____

Address _____

City _____ State _____ Zip _____

Email Address: _____ @ _____ .COM

(This email address is used to email you reminders of your appointment.)

Your Birthday: _____ / _____ / _____

Would you like to receive our email newsletters which are sent out approximately every 4-6 weeks: _____ Yes _____ No

Home Phone # _____ / _____ / _____

Office Phone # _____ / _____ / _____

Cell Phone # _____ / _____ / _____

Emergency Contact Information- to be completed by all clients/patients

Name of Emergency Contact: _____

Cell Phone # _____ / _____ / _____ Other Phone # _____ / _____ / _____

Relationship: _____

Who can we thank for referring you to us? _____

How did you learn about Essence of Eve? _____

How much water do you consume daily approximately _____

Waiver Of Liability & Your Signature

I understand that all service providers are licensed as required and that they are not intended to prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. It has been made very clear to me that these services are not a substitute for medical examinations and/or for diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because all therapists must be aware of existing physical conditions as well as any medications that I am on, I will state all my known medical limitations and medications and take it upon myself to keep the therapists who provide services updated on my physical health in an ongoing manner.

Signature: _____ Date: _____

General Health Information - to be completed by all clients/patients

Check only items applicable and if needed provide brief explanations. Your therapist may ask additional questions and document your responses in your medical chart which we keep for future reference and documenting your ongoing care.

___ Currently Use Tobacco products

I have been diagnosed with a form of Hepatitis _____ a blood-born disease(s) ___ I am taking Blood thinners ___
(Please explain or describe in more detail:)

___ Allergies (Food, Medication, Animal, Seasonal -

(Some products which we may use for treatments may include plants, fruits, nuts, etc., which we will want to avoid should you have an allergic reaction. PLEASE BE THOROUGH)- please denote _____

If you currently have been diagnosed or have ever been diagnosed with cancer, what type of cancer?

Approximate date of cancer diagnosis? _____

If you are currently undergoing any form of treatment for your cancer diagnosis please describe?

I currently am Pregnant _____ plan on becoming pregnant _____ currently taking fertility drugs _____.
(If any of these checked please note number of weeks pregnant, how long fertility drug has been taken, etc.)

___ Currently a Nursing Mother

___ I have had surgery within the past 12 months on the approximate date of _____

Surgery was for: _____

___ Do you have aversions to certain smells and/or fragrances? Please list specifically, eucalyptus, lavender, rose etc.

___ Hormone Imbalance ___ Skin Disorders/Diseases ___ Metal Implants ___ Pacemaker
___ HIV/Aids ___ Migraine Headaches ___ Insomnia ___ High Blood Pressure
___ Herniated Disc ___ Arthritis ___ Varicose Veins ___ Neck/Back Pain ___ Diabetes
___ Sciatica ___ Eczema ___ Athletes Foot Fungus
___ Thrombophlebitis ___ Heart Problems ___ Psoriasis ___ Claustrophobia

General Health Information - to be completed by all clients/patients

I have these concerns pertaining to my health: _____

Check items that you have had reactions to.

___ Cosmetics ___ Fruit ___ Vegetables ___ Fragrances

___ Aspirin ___ Herbs ___ Essential Oils ___ Sun screens

If you checked any of the above please describe: _____

___ Use sun screen SPF # _____

___ Participate in any outdoor activities

___ Tendency for redness

___ Take stimulants

___ Have sinus problems

___ Wear contact lenses

___ I have seen a Dermatologist in the past year. If you have, list reason for visit _____

___ I am presently under physician's care for the following reason(s) _____

What medications do you take on a regular basis? _____

For Facial Clients Only

Are you using or have you ever used any medications for acne? _____

___ Have you ever had Herpes (cold sores)?

___ Have you ever been treated for Herpes (cold sores)?

___ Facial Chemical Peels - If checked how many _____? When was last peel? _____

___ Use/Used Retin A - If checked how long? _____ When? _____

___ Use/Used Accutane - If checked how long _____ When? _____

Please list any skin conditions you may want to improve: _____

For Massage Clients Only

What type of massage pressure do you prefer (light, medium, deep) _____

Please list any injuries or special concerns you may have pertaining to your body for massage:

PLEASE INITIAL THE FOLLOWING STATEMENTS

“I understand during my service at Essence of Eve Day Med Spa:

_____ Conservative draping will be practiced by my therapist throughout the session.

_____ The massage is therapeutic, and no genital or sexually oriented contact will occur.

_____ There will not be breast massage during session.

_____ If I am uncomfortable at any time, I can request the session to end.

_____ I am responsible to update my therapist if there are any changes in my health over time.

_____ My therapist will not diagnose, treat, or prescribe, as would a Medical Doctor.

_____ My therapist manipulates soft tissue of the body, and can work with my other healthcare providers to enhance my wellness and overall health.

_____ My session is intended solely for the purposes of stress reduction, relief of muscle tension or spasms, and to increase circulation and energy in my body systems.”

Client/Guardian Signature _____

Date _____

Client/Minor Signature _____

Date _____