



Welcome! Our goal is to deliver the most pleasurable spa experience... In order to customize your experience and assure your satisfaction and safety, please complete the questions below. This will help us design the ideal program for you!

Name _____ Home Phone _____
Address _____ Cell Phone _____
City/State/Zip _____ Occupation _____
E-Mail Address _____ Date of Birth _____

Preferred Method of Contact: Phone Text Email

How did you hear about us? _____

Are you interested in learning how to take better care of your skin body diet well being

What are your skin concerns? Please check all that apply.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Dry | <input type="checkbox"/> Oily | <input type="checkbox"/> Combination | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Dehydration | <input type="checkbox"/> Sensitivity | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hyper/hypo pigmentation | <input type="checkbox"/> Loss of Elasticity | <input type="checkbox"/> Uneven Skin Texture | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Blackheads | <input type="checkbox"/> Whiteheads | <input type="checkbox"/> Skin Irritations |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Large Pores | <input type="checkbox"/> Dilated Capillaries | <input type="checkbox"/> Other _____ |

Please advise us of your medical history.

- | | | | |
|-----------------------------------|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> RA/ Lupus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Headache | <input type="checkbox"/> HIV/Hepatitis | <input type="checkbox"/> None of the Above |

Surgery in the last 12 months? _____ If yes, please specify _____

Have you had any resurfacing treatments in the last month? yes no

Do you use or have you used Accutane or RetinA, or any other prescription skin products? yes no Date and product last used? _____

Are you currently using any products that contain the following ingredients?

- glycolic acid lactic acid any hydroxyl acid product any exfoliating scrubs RetinA

Have you had an allergic reaction to any of the following? fruit dairy seafood cosmetics medicine

- pollen food hydroxyl acids fragrances sunscreens benzoyl peroxide latex aspirin
 other _____ if yes what? _____

Have you ever had an allergic reaction to skincare products? _____ If yes, what ingredient? _____

What skin care products are you currently using? retinol cleanser toner moisturizer masque
 exfoliator eye products sunscreen cleansing brush

What skincare line do you use? _____ What makeup line do you use? _____

What type of massage pressure do you like? light medium firm

Are you currently pregnant or trying to become pregnant? yes no Breastfeeding? yes no

Liability Waiver: I declare that I am with full legal capacity and physical condition to obtain skin care/ body treatments. I have correctly answered the questions and have not withheld any information that may be relevant to my treatment. I hereby acknowledge and agree to obtain treatment. The possible risks of injury and/or disease which I may sustain personally will be my full and complete responsibility. Through this writing, I release my therapist and Déjà Vu Med Spa.

Client Signature: _____ Date: _____