Remedial Wellness Centre

Confidential Case History Form for Aesthetics

Date: _____

Name: _____ ☐ MALE ☐ FEMALE

Date of Birth: _____ (dd/mm/yyyy) Occupation: _____

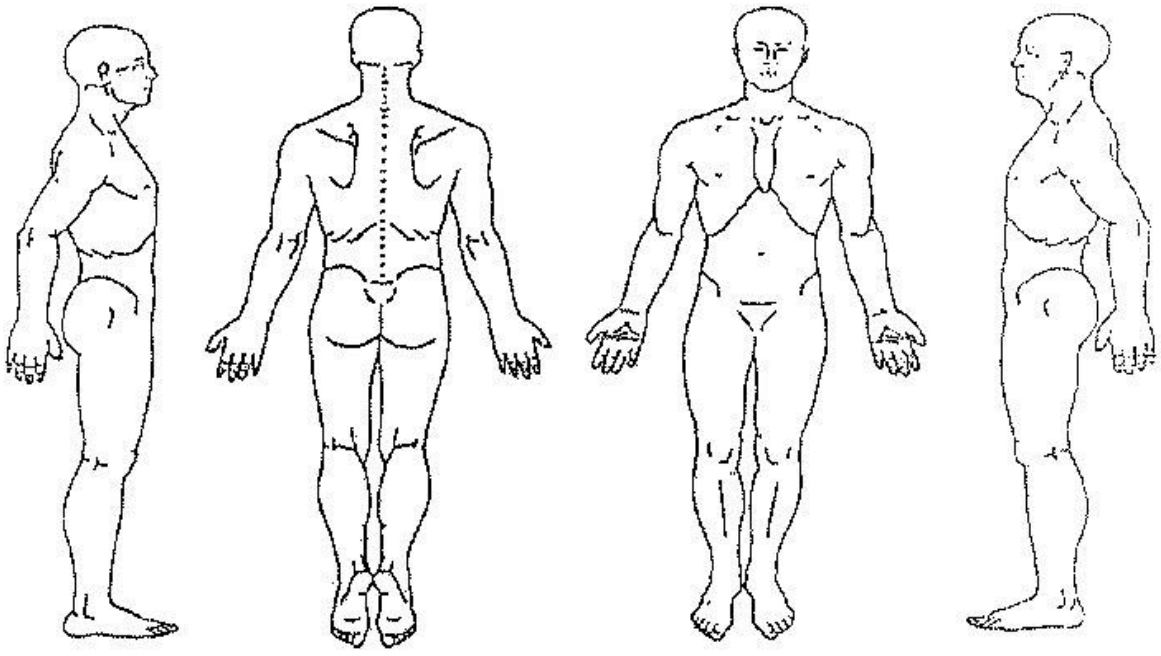
Address: _____ City_____ Prov: _____

Postal Code: _____ Home Phone: _____ Email: _____

Medical Doctor:_____ MD Phone:_____

How did you hear about us? _____

Please indicate (circle) for the therapist where your problem areas are located:



Please indicate any conditions you are experiencing or have experienced:

Cardiovascular
□ High Blood Pressure
□ Low Blood Pressure
□ Chronic congestive heart failure
□ Heart Attack
□ Phlebitis/Varicose veins
□ Stroke/CVA
□ Pacemaker or similar device
□ Heart Disease
□ Dizziness/Vertigo
□ Seizures
□ Hemophilia
□ Blood Clots

Respiratory
□ Asthma
□ Bronchitis
□ Emphysema
□ Chronic Cough
□ Shortness of breath

Digestive
□ Constipation
□ Crohn's Disease
□ Colitis
□ Irritable Bowel Syndrome
□ Ulcers

Head, Jaw & Face
□ History of headaches
□ Migraines
□ Vision problems
□ Vision loss
□ Ear problems
□ Hearing loss

Muscle & Joint
□ Neck
□ Low-Back
□ Mid-Back
□ Upper-Back
□ Shoulders
□ Elbow
□ Wrist/Hand
□ Hip
□ Knee
□ Ankle/Foot
□ Spine

Systemic Conditions
□ Diabetes
*Onset:*_____
Type: _____
□ HIV/AIDS
□ Hepatitis
□ Arthritis
□ Fibromyalgia
□ Chronic fatigue
□ Polio/Post polio
□ Osteoporosis
□ Epilepsy
□ Restless Leg Syndrome

Skin Conditions
□ Eczema
□ Psoriasis
□ Rash
□ Warts
□ Open Sores

Other
□ Loss of sensation
If so, where?
_____
_____

□ Allergies
To what?
_____
_____

□ Cancer or history of
Type: _____
Location: _____
Date of Remission:
_____

Foot Health
□ Athlete's Foot
□ Bacterial or Fungal Infection
□ Dry Skin
□ Corns or Calluses
□ Warts
□ Cracked Heels
□ Bunions
□ Prone to Cold Feet
□ Sweaty Feet
□ Ingrown Toenails
□ Spurs
□ Hammer Toe
□ Numbness/Tingling
□ Peeling Skin
□ Rough Skin
□ Foot or Shoe Odor
□ Tired/Swollen Legs
□ Areas sensitive to pressure/touch. *If yes, where?*
_____

Hand & Nail Health
□ Bacterial or Fungal Infection
□ Dry Skin
□ Ganglion Cyst
□ Warts
□ Carpal Tunnel Syndrome
□ Cracked Skin
□ Prone to Cold Hands
□ Ingrown Nails
□ Arthritis
□ Hand/Finger Injuries
□ Numbness/Tingling
□ Psoriasis on hands
□ Hives on hands
□ Eczema on hands
□ Areas sensitive to pressure/touch. *If yes, where?*
_____

Women
□ Are you pregnant?
□ YES □ NO
If yes, due date? _____
□ Have you had a c-section?
□ YES □ NO
□ Have you had a hysterectomy?
□ YES □ NO

□ Previous pregnancy complications:
_____
□ Menopausal problems:
_____
□ Menstrual problems:
_____
□ Gynecological conditions:
_____

Men
□ Enlarged Prostate
□ Erectile Dysfunction
□ Peyronie's Disease
□ Libido Issues
□ Other:
_____

Do you have any medical or skin conditions not listed above? □ YES □ NO

If yes, please explain:

_____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of? □ YES □ NO
If yes, please explain:

_____

Have you seen any other health care professional(s) for this condition? □ YES □ NO
If so, whom?

_____

Briefly list any surgeries you have undergone, for what and when:

Date	**Procedure**	**Comments**

Are you presently taking any prescribed medications? □ YES □ NO

If yes, please list the medication(s) and the condition(s) for which it is being used if known. This also includes hormonal replacements, birth control pills and antibiotics.

Medication Name	**Dosage**	**Condition Treated**	**Prescribing MD**

Skin Care History

	YES	NO	More Information
Have you ever received professional skin care treatment before?			Date of last treatment:
Do you have a skin care regime?			Products used: - . - . - . - . - .
Are you currently under a physician's care for a skin condition or any other health issue?			Name of physician: Condition:
Do you experience frequent blemishes?			
Have you ever had acne?			
Do you experience oily skin or shine during the day?			
Do you exfoliate your skin?			Frequency:
Do you ever have an ashy complexion?			
Do you experience flakiness or tightness?			
Do you flush easily?			
Do you have extreme redness at anytime?			
Do you work outdoors or indoors?			□ OUTDOORS □ INDOORS
Do you spend most of your free time outdoors or indoors?			□ OUTDOORS □ INDOORS
Are you using Acutane, Azelex, Renova, Retin-A (retinol), Tazarac, or products with Glycolic or Alpha Hydroxy Acids?			Names:
Have you ever received Micro-dermabraion, Enzyme Peels, Acid or Chemical Peels, or Waxing Services?			Type of treatment: Date of last treatment:
Do you have any negative reactions to cosmetics, iodine, shellfish, fruits, or vegetables?			List sensitivities: - . - . - .
Do you use sun protection?			Product Used: Frequency:
Please intake your level of daily water intake.			□ LOW (<1L) □ MEDIUM(1-2L) □ HIGH(2+L)
Are you claustrophobic or do you have sensitivities around your neck or upper body?			Comments:

Informed Consent to Aesthetics Treatments

I acknowledge that the Registered Aesthetician is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that this treatment is not a substitute for medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided me as the results of the treatment. I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur.

To ensure my safety, I have given an accurate account of my medical history including all known allergies or prescription drugs or products I am currently ingesting or using topically. I acknowledge and understand that the Registered Aesthetician must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Registered Aesthetician and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Registered Aesthetician updated on my medical history. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my aesthetician as soon as possible. For my own relaxation and that of other clients I will silence my cell phone and refrain from making or receiving calls until my service is complete.

The information I have provided is true and complete to the best of my knowledge. By signing this confidential form I agree to the above terms and release Remedial Wellness Centre and its employees from any liability.

_____

Signature of Client Date

_____

Signature of Witness Date

Aesthetics Cancellation Policy

Please be advised that there is a 12 hour missed/cancelled appointment policy in effect for any services at Remedial Wellness Centre. Late cancellations (within 12 hours) and missed appointments will be charged 50% of the appointment fee. The same applies if the therapist misses an appointment with a client; (the client's next appointment will be 50% of the full fee).

In order to be consistent with all clients, cancellation fees will only be waived in the event of a medical emergency requiring urgent professional treatment, a major event in the family or natural disaster. We are committed to providing you with the highest quality service possible and we ask that you understand that it is nearly impossible to fill appointments spots on the day they are cancelled. Thank you for your understanding and we look forward to helping you on your way to better health.

I hereby confirm that I have read, understand and agree to the above terms.

_____

Signature of Client Date

_____

Signature of Witness Date