Name:	Date:	Occupation:
Address:	Phone:	Date of Birth:
City: State:	Zip Code:	Email:
Cell: Phone:	Contact me by: __Text __ Cell	Emergency Contact/Relationship/Phone:
How did you hear about us:	Referral Name:	

General Health

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1
2. Are you pregnant or nursing? Yes No
3. Do you wear contact lenses? Yes No
4. Do you smoke? Yes No How many cigarettes per day?
5. Please list any accidents or surgeries in the last 12 months:
6. Do you have any metal implants, a pacemaker or body piercings?
7. Please list previous cosmetic/plastic surgeries:

Current prescription medications:	Current over the counter medications:

Health History (please circle)

Heart Condition	Lymphedema	Herpes/Shingles	High Blood Pressure	Low Blood Pressure
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	
Rashes	Jaw Pain/TMJ	Blood Clots	Constipation	
Diabetes	Gas/Bloating	Headaches	Arthritis	
Broken/Fractured Bones	Pregnancy (___ weeks)	Fatigue/Sleep Disorder	Depression/Anxiety	Cancer

Other (explain):

Skin Care (please circle)

1. Are you under the care of a dermatologist? Yes No
2. Do you use: Accutane Retin A Renova Adapalene Other prescription skin products __________________
3. Have you had a: Chemical Peel Microdermabrasion Botox Other resurfacing treatments
4. Are you currently using any products that contain: Glycolic Acid Lactic Acid Hydroxy Acid Vitamin A
5. Do you have any skin sensitivities? Yes No If yes, please list:

Skin Maintenance (please circle)						
Products You Use:	Soap	Cleanser	Toner	Moisturizer	Exfoliator	Masque
Skin Type:	Oily/Congested	Dry/Dehydrated	Sensitive/Redness	Acne	Sunburned	
Do you have any of the following?						
Eczema	Claustrophobia	Psoriasis	Iodine or Shellfish allergy	None		
Have you been tanning in the last 24 hours? Yes No	Are you going or coming from a vacation? Yes No					
What are your skin care/aesthetic goals?						

It is my choice to receive services from Soma Medical Spa. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and will update the staff at Soma Medical Spa of any changes to my health status.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 48 hours in advance by phone, unless I have an emergency. In this case, I will call as soon as possible to reschedule my appointment. If I miss a scheduled appointment without giving 24 hour notice, I agree to pay the missed appointment fee that applies.

Name ____________________ Date ____________________