AOB
ALL OVER BEAUTIFUL
MED SPA

MindBody ID# __ __ __ __ __ __ __ __ __ __

CLIENT INFORMATION AND MEDICAL HISTORY

First Name **Last Name**

Street Address **City** **State** **Zip** **Phone Number**

Email Address **Birthdate**

Employer **How did you hear about us?**

Emergency Contact **Phone Number** **Relationship**

Concerns with your skin/body: (check all that apply)

- ○ Rosacea
- ○ Broken Capillaries
- ○ Sun Damage
- ○ Fine Lines
- ○ Deeper Wrinkles
- ○ Dry/Dehydrated Skin
- ○ Acne
- ○ Oily Skin
- ○ Uneven Skin Tone
- ○ Large Pores
- ○ Ingrown Hairs
- ○ Excess Fat
- ○ Unwanted Hair
- ○ Coarse Hair
- ○ Other_____

Services you are interested in: (check all that apply)

- ○ Photofacial
- ○ Chemical Peels
- ○ TCA/Jessner Peels
- ○ Facials
- ○ Microdermabrasion
- ○ Microneedling
- ○ Hair Removal (list areas):
  - ○ _____
  - ○ _____
- ○ CoolSculpting
- ○ Dermaplaning
- ○ Skincare Regimen
- ○ Botox
- ○ Fillers
- ○ Lashes and Makeup
- ○ Other _____

Medical History: (Check all conditions you currently have or have ever had below)

____ Chronic or acute skin diseases, such as herpes (including cold sores), psoriasis or eczema
____ Sun or other light allergies or allergy symptoms (rashes, itching and hives), light sensitivity, or histamine reactions (redness, headaches, vomiting, diarrhea)
____ Disease of adrenal glands or kidneys
____ Infectious diseases or current infections (HIV, Hepatitis)
____ Blood coagulation diseases, such as thrombosis (blood-clots, phlebitis, embolism)
____ Hormonal imbalance
____ Diseases of the nervous system, such as epilepsy
____ Endocrine and autoimmune diseases, such as diabetes, porphyria, or lupus
____ Cancer

_____ _____
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Medical History *Continued* (Check all conditions you currently have or have ever had below)**:**

____ Heart or vascular disease (high blood pressure, peripheral artery disease, heart failure)
____ Cryoglobulinemia or paroxysmal cold hemoglobinuria
____ Known sensitivity to cold such as cold urticaria or Raynaud's disease
____ Impaired peripheral circulation in the area to be treated
____ Neuropathic disorders such as post-herpetic neuralgia or diabetic neuropathy
____ Impaired skin sensation
____ Open or infected wounds
____ Bleeding disorders or use of blood thinners
____ Recent surgery or scar tissue in the area to be treated
____ A hernia or history of hernia in the area to be treated or adjacent to treatment site
____ Skin conditions such as eczema, dermatitis, or rashes
____ Any active implanted devices such as pacemakers and defibrillators

Additional Questions:

Are you under the care of a physician or dermatologist?
No / Yes (please provide their names and condition(s) being treated) _____

Do you currently take, or have you taken, any medication other than contraception or thyroid hormones, within the week preceding any treatment?
No / Yes (if yes, we may need to postpone the session to one week after the last medication is taken, or if medication is taken daily, you may need to obtain written confirmation from your doctor saying you may receive a treatment)
Please list current medications: _____

Are you using any prescription topical or oral medications or creams, including Retin-A products, skin lightening creams and acne prescriptions such as Accutane/Isotretoin?
No / Yes (please specify and indicate the last time used) _____

Are you allergic to any medications, products or food?
No / Yes (please specify) _____

Have you had a vaccination within the last 72 hours?
No / Yes (if yes, the session must be postponed until at least 72 hours after the vaccine injection)

Do you have a pacemaker, implants or a prosthesis?
No / Yes If so, in which part of the body? _____

Do you use any vitamin or herbal supplements?
No / Yes (please specify)_____

Do you sunbathe, visit tanning salons or use tanning products?
No / Yes (please specify)_____

_____ _____
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Additional Questions *Continued*:
Do you have any permanent make-up or tattoos?
No / Yes If so, in which part of the body? _____

Have you received Botox or Dermal Fillers?
No / Yes If so, last injection: _____

Do you have any raised scaring issues with your skin, such as diagnosed keloid or hypertrophic?
No / Yes (please specify)_____

Please list all products used in skin care regime and/or used on area being treated: (cream, essential oils, ointment, etc.)
_____

Are you pregnant or breastfeeding?
No /Yes

Have you had a skin care treatment (micro-derm, chemical peel, laser, etc.) within the past week?
No / Yes (please specify) _____

_____ _____
Client Signature (or Responsible Guardian) Date

_____ _____
Witness Date

_____ _____
Tech Initials Date