Client Health History: Microcurrent

Name: _____

Address: _____City: _____State: _____Zip:_____

Home/Cell Phone: _____ Work Phone: _____

Email: _____How should we contact you? Home/Cell Phone: __ Work Phone: __ Email: __

When is the best time to contact you? Morning: __ Daytime: __ Evening: __

How did you hear of us? _____ Emergency contact name: _____

Phone: _____ Relationship to you: _____

Health History

Please list any allergies you have: _____

_____

Please list all current medications you are taking (including oral and topical prescriptions, over-the-counter herbs, vitamins and supplements):_____

_____

These questions are relevant to your skin health and may be contraindications for treatment. Please answer thoroughly.

Question	Y	N	Details *If applicable*	Adverse Reactions? *If applicable*
Are you pregnant or nursing?				
Do you wear contacts or glasses?				
Do you have any metal implants, including plates, screws or pins?				
Do you have any metal piercings?				
Do you use a pacemaker?				
Do you have any heart problems?				
Do you have high/low blood pressure?				
Do you have braces, metal fillings or other dental implants?				
Do you currently have a cold or flu?				
Do you have an autoimmune disorder or connective tissue disease?				
Have you had any previous facial treatments?				
Do you use Retin-A®, Accutane® or any other prescribed topical Vitamin A derivative?				
Have you ever had Botox®, Juvederm®, or any other injectable?				

Have you ever had any of these conditions? (Please circle)

Acne rosacea	Bell's palsy	Cold sores	Diabetes	Embolism	Epilepsy
Light sensitivity	Melanoma	Migraines	Open wounds	Phlebitis	Recent scar tissue
Sensitive skin	Skin inflammation/ disorders	Stroke/TIA	Thrombosis	Thyroid conditions	Varicose veins

Any other health condition not listed: _____

_____

Is there anything else we should know about? _____

_____