Beautique
MEDICAL SPA an anti-aging clinic

Client Health & History Information

Q#: ____________________ Consultant: ____________________

Last Name: ______________________________ First Name: ______________________________

Address: ____

City: ______________________________ State: __________ Zip: ______________________

Email Address: ____

Home Phone: ____________________________ Work Phone: ______________________________

Cell Phone: ____________________________ Birthday (M/D/Year): ____________ Age: ________________

❑ Yes, add me to your mailing and email lists to receive information on promotions and events. (We respect your privacy and will never rent, sell or share your information.)

Which of the following methods should we use to contact you? (Please check all that apply.)

❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email ❑ Text ❑ Regular Mail

Do we have permission to leave messages with anyone other than you? ❑ Yes ❑ No

Which of the following interest you most (Check all that apply.)

❑ BOTOX Cosmetic
❑ Dermal Fillers (Juvederm, Radiesse, Voluma)
❑ Wrinkle Removal
❑ Thermage (Face, Body)
❑ Chemical Peels (Jessner, AHA, Glycolic, TCA)
❑ Microdermabrasion/Silk Peel Dermalinfusion-Face, Body
❑ Laser Treatments
❑ Skin Rejuvenation
❑ Skin Toning/ Pore Reduction
❑ Sensitive Skin Management
❑ Facial Redness/Rosacea
❑ Facial/Leg Veins
❑ Sun Damage (Brown Spots)
❑ Acne
❑ Skin Care/Skin Care Products
❑ Makeup
❑ Inadequate Lashes
❑ Cellulite Therapy
❑ Body Contouring
❑ Weight Loss
❑ Hair Removal
❑ Sweaty Hands/Feet
❑ Facials/Eye Treatments
❑ Other ______________

How did you hear about Beautique?

❑ Relative/Friend—Name: ____________________
❑ AT&T Yellow Pages Ad
❑ Newspaper—Which one? __________________
❑ Outdoor Sign
❑ TV—Which channel? ______________________
❑ Mail/Flyer
❑ Radio Station—Which one? _________________
❑ Event—Which one? ________________________
❑ Facebook
❑ Twitter
❑ Dermanetwork
❑ Yelp
❑ BMS Website
❑ www.BotoxCosmetic.com
❑ www.Radiesse.com
❑ www.JaneIredale.com
❑ Other—Please specify: ______________

YOUR HEALTH:

Have you had any of the health problems or do you have?

❑ Cancer
❑ Diabetes
❑ Epilepsy
❑ Heart Problems
❑ Hormone Imbalance
❑ Hypertension
❑ Spinal Injury
❑ Hysterectomy
❑ Thyroid Condition
❑ Varicose Veins
❑ Systemic Disease
❑ HIV Positive
❑ Liver
❑ Kidney
❑ Asthma
❑ Lung
❑ Constipation
❑ Other ______________________________
❑ Blood Disease
❑ Hemophiliac
❑ Stroke
❑ Thrombosis
❑ Pulmonary Embolism

If yes, explain: ____

Do you follow a restricted diet? ❑ Yes ❑ No
Have you had a significant weight loss or weight gain in the past 6 months? ❑ Yes ❑ No
Do you take any vitamins, drugs, blood thinners, diet pills or minerals? ❑ Yes ❑ No
List any medications you take regularly:
Supplements: ____
Medications: ____
Do you smoke? ❑ Yes ❑ No
Do you experience irregular sleep patterns? ❑ Yes ❑ No
Do you have metal implants or a pacemaker? ❑ Yes ❑ No
Are you allergic to shellfish or iodine or skin care products/ingredients? ❑ Yes ❑ No
If yes, explain: ____
Have you ever had blood clots? ❑ Yes ❑ No

YOUR SKIN

What is your main area of concern?
Please specify: ____
What skin care products are you currently using? Brand: ________________________________
❑ Soap ❑ Serums ❑ Toner ❑ Exfoliant ❑ Eye Products
❑ Cleanser ❑ Night Cream ❑ Moisturizer ❑ Mask ❑ Others

EXFOLIATION HISTORY

Have you ever had chemical peels, laser, microdermabrastion or any resurfacing treatments? ❑ Yes ❑ No
❑ in the last month? ❑ in the last three months? ❑ in the last six months?
Are you currently using any products that contain the following ingredients? ❑ Yes ❑ No
Please check all that apply:
❑ Glycolic Acid ❑ Any Hydroxy Acid Product ❑Accutane
❑Retin A ❑Renova ❑Adapalene (Differen)
❑ Lactic Acid ❑ Vitamin A Derivatives (Retinol) ❑ Exfoliating Scrubs
❑ Hydroquinone ❑ Other: ____________________

NERVE ACTIVITY

Do you drink caffeinated beverages (coffee, tea soft drinks)? ❑ Yes ❑ No
How many daily (all combined)? ___________
Do you ever experience a burning, itching sensation on your skin? ❑ Yes ❑ No
Where? Explain: ____
How is your pain tolerance? ❑ Low ❑ Medium ❑ High
Have you ever experienced claustrophobia? ❑ Yes ❑ No

FEMALE CLIENTS ONLY

Are you taking oral contraceptives? ❑ Yes ❑ No
Have you changed brands of contraceptives in the last 6 months? ❑ Yes ❑ No
Are you pregnant or trying to become pregnant? ❑ Yes ❑ No
Is your menstrual cycle (period) regular? ❑ Yes ❑ No

MALE CLIENTS ONLY

Do you experience ingrown hairs or bumps under your skin? ❑ Yes ❑ No
Are you interested in hair removal? ❑ Yes ❑ No

SPA POLICIES

I agree for my file to be shared with all staff, and I agree for all
my information to be used for research. ❑ Yes Initial _______

I confirm (to the best of my knowledge) that the answers I have given on all pages are correct and that I have not withheld any information that may be relevant to my treatment.

Signature: ____ Date: __________________

Policy Agreement

Sign and and initial at the areas provided to indicate that the following policy agreement has been read, understood and accepted. Completion is required prior to the rendering at any clinic services or product purchases. If you are under age 18, a signature is required by a parent or legal guardian.

Initial

____ I understand that payment for all services and products is due at the time of services. Beautique Medical Spa accepts MasterCard, Visa, Discover, American Express, Credit Care financing and cash. **We do not accept checks**.

____ I will be on time for my appointment. If I am running late, I will call Beautique to notify my skin specialist. Delays exceeding 15 minutes may require rescheduling. A Beautique representative will provide the same courtesy call should a delay be expected on our part that exceeds 15 minutes.

____ I understand that all series and packages purchased must be used within one calendar year starting with your first treatment.

____ I understand there are NO REFUNDS on products, only exchanges. All makeup sales are final. Non-stocked items and special order products must be paid in advance. All special orders are final and are not eligible for exchange or refund.

____ If I develop an allergy or experience product irritation, I will call the clinic within 24 hours. Exchanges will be honored within 14 days of purchase, container must be 3/4 full and exchange must be authorized by a skincare specialist.

____ All client information and records are confidential unless you authorize consent for us to communicate with another party.

____ I agree that I will keep my skin care specialist informed of any changes in my homecare routine, lifestyle and health which could directly affect the results I am seeking from clinic services. I will bring any medications, oral and topical, that are prescribed by any outside source or physician.

____ I authorize Beautique to take photographs at any point in my skin care management as is considered necessary for my client records. These photographs are for client/technician reference only.

____ Any photographs for publication, journals or advertising will require my consent below. (Please check yes or no.)

- ❑ Yes, I give permission to use my photos for educational and marketing purposes.
- ❑ Filled out photo release form. BMS REP: ______________ Date: ______________
- ❑ No, I do not give permission to use my photos for educational/marketing purposes.

____ I authorize Beautique to charge my credit card on file for recurring payments, special and pre-orders, no-show fees and phone orders.

No-Show/Cancellation Agreement

24-Hour Rescheduling Notice

A 24-hour rescheduling notice is required to avoid last minute cancellation fees. We understand that life can "get in the way" from time to time, but we ask that you let us know out of consideration to our service providers who work so hard for you. This is why we ask for a 24-hour cancellation notice if you are unable to make an appointment. If you simply do not show up for an appointment, you will be subject to a no-show fee of 50% of service(s) scheduled ***if*** a cancellation call **is not** received and documented by a Beautique representative. In order to avoid the fee, **verbal communication with a staff member is required**. We will not accept cancellations from text messages, email, or Facebook, etc. Your initials: ____

No-Show Fee

The no-show fee enables our service providers to be compensated for appointments that are not kept. We know you love our staff and can understand why we ask for your cooperation. Your initials: ____

Appointment Reminders

To help you avoid missing an appointment, we give you five reminders:

1. One week before your scheduled appointment you will receive an email reminder. This is your first opportunity to reschedule.
2. Two days before your scheduled appointment you will receive an additional email if you have not already confirmed.
3. Two days before your appointment our Customer Service Reminder will call you to confirm your appointment. If she cannot reach you she will leave you a message. If you do not return her message it is assumed that you will keep your appointment. If you miss your appointment you will be charged the no-show fee.
4. The day of your appointment you may receive a call if we still have not heard from you.
5. The day of your appointment you will receive an email and text message reminder.

If you have an emergency preventing you from keeping your appointment, call (956) 664-1234 and we will work something out. If you are unable to call that day because of an actual emergency, let us know what happened as soon as possible. We are always concerned about your well-being. Your initials: ____

Your signature below indicates the following policy agreement has been read, understood and accepted. Completion is required prior to the rendering of any clinic services or product purchases. If you are under age 18, a parent/guardian signature is required.

I understand it is my responsibility to notify Beautique if I am unable to keep my appointment. I authorize my card on file to be charged with 50% of service(s) missed as a no-show fee. I will receive a receipt via standard mail for this.

By signing for the minor, I understand that I act as their guarantor for these policies.

Client Signature: ____ Date: ____________________

Client Name (Printed): ____

Parent/Guardian Signature: ____