BODY TREATMENT CONSULTATION

DAWNING tranquility

Client Name: _____ DOB (mm/dd): _____

Address: _____ ☐ under 21 ☐ 21-30 ☐ 31-40

_____ ☐ 41-50 ☐ 51-60 ☐ 60+

Phone: _____ c h w Phone: _____ c h w Email: _____

Emergency Contact (Relationship) _____ Phone_____

How did you hear about us? _____

Your Health

Occupation: _____ Rate your level of stress on a scale of 1 to 5 *(1 = low stress, 5 = high stress)* _____

What is your pain threshold? ☐ low ☐ medium ☐ high

Within the last year, have you been under a physician's care for post-surgery, physical therapy or chiropractic care? *Y N*

If yes, explain: _____

Within the last twelve months, have you undergone any surgery? *Y N* If yes, explain: _____

Do you have any areas of discomfort? *Y N* If yes, explain: _____

Have you recently experienced any of the following types of pain? ☐ n/a

☐ sharp ☐ throbbing ☐ numbness ☐ shooting ☐ burning ☐ tingling ☐ swelling

☐ dull ☐ aching ☐ stiffness ☐ cramps ☐ other: _____

Does this pain interfere with any of the following? ☐ n/a

☐ work ☐ sleep ☐ daily routine ☐ exercise/recreation

Are any of the following activities or movements painful to perform? ☐ n/a

☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down

Do you have any known allergies? *Y N* If yes, specify: _____

Have you ever had a reaction to any of the following?

☐ cosmetics ☐ medicine ☐ hydroxy acids ☐ animals ☐ iodine ☐ fragrance/scents

☐ food ☐ pollen ☐ sunscreens ☐ other: _____

List any medications, supplements, vitamins, diuretics etc. you take regularly (topical and/or oral) and the purpose:

_____

_____

Do you smoke? *Y N* Do you exercise regularly? *Y N* Do you follow a restricted diet? *Y N*

Do you wear contacts? *Y N* Do you have metal implants, a pacemaker or body piercings? *Y N*

How much plain water do you consume daily? _____ How many alcoholic beverages do you consume weekly? _____

Do you ever experience these conditions on your skin: ☐ flakiness ☐ tightness ☐ obvious dryness

Your Medical History

Please check conditions or symptoms you currently have or have had in the past:

☐ Acne	☐ Carpal Tunnel	☐ Head Injuries	☐ Migraine/Headaches	☐ Sciatica
☐ Anemia	☐ Claustrophobia	☐ Hearing Loss	☐ Multiple Sclerosis	☐ Shingles
☐ Anorexia	☐ Communicable Disease	☐ Heart Attack	☐ Neuropathy	☐ Sinus Issues
☐ Appendicitis	☐ Diabetes	☐ Heart Disease	☐ Osteoporosis	☐ Sprains/Strains
☐ Arthritis	☐ Dry Skin	☐ Hepatitis	☐ Pacemaker	☐ Stroke
☐ Anorexia	☐ Eczema	☐ Herniated Disk	☐ Parkinson's Disease	☐ Tendonitis
☐ Asthma	☐ Emotional Instabilities	☐ Herpes	☐ Pinched Nerve	☐ Thyroid Issues
☐ Blood Clots	☐ Emphysema	☐ Hernia	☐ Pneumonia	☐ Tonsillitis
☐ Blood Pressure	☐ Epilepsy	☐ HIV/AIDS	☐ Polio	☐ Tuberculosis
☐ Breathing Difficulty	☐ Fatigue	☐ Jaw Pain/TMJ	☐ Prosthesis	☐ Tumors/Growths
☐ Bursitis	☐ Fibromyalgia	☐ Joint Pain	☐ Rashes	☐ Ulcers
☐ Bronchitis	☐ Fractures	☐ Kidney Issues	☐ Rheumatic Fever	☐ Varicose Veins
☐ Bulimia	☐ Glaucoma	☐ Loss of Appetite	☐ Rheumatoid Arthritis	☐ Whiplash
☐ Cancer	☐ Gum Disease	☐ Lymphedema	☐ Other: _____	

Your Skin

Skin Type: ☐ Sensitive ☐ Dry ☐ Combination ☐ Oily

Do you have any special skin problems or specific concerns pertaining to your face or body?

If yes, specify: _____

What skin care products are you currently using?

Face: ☐ soap ☐ cleanser ☐ toner ☐ moisturizer ☐ masque ☐ exfoliator ☐ eye products

Body: ☐ soap ☐ shower gel ☐ scrubs/exfoliants ☐ oil ☐ body moisturizer ☐ depilatories ☐ self tanners

Skin Care Brands Currently Using: _____

Do you burn easily in moderate sunlight? *Y N*

Do you ever experience skin breakouts? *Y N* If yes, explain: _____

Do you ever experience a burning, itching sensation on your skin? *Y N*

Do you experience irritation from shaving? *Y N* Do you experience ingrown hairs? *Y N*

I understand, have read and completed this questionnaire truthfully and to the best of my knowledge. I agree that this constitutes as full disclosure and supersedes any previous verbal or written disclosures and precedes all future treatments. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I understand that services received are a therapeutic aid and are non-sexual. I understand this treatment does not diagnose illness or disease and that it is not a substitute for medical examination or medical care, and that it is recommended that I concurrently work with my primary caregiver for any conditions I may have. The treatments I receive here at Dawning Tranquility are voluntary and I release this institution and/or the servicing technician from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____