# Ritual Self Care

**314 Clifton Avenue**
**Carriage House**
**612.280.3000 / www.ritualselfcare.earth**

## SKIN CARE CLIENT HEALTH HISTORY

**Personal Information :**

Name _____ Date_____

Email Address_____

Phone _____Birthday _____

Emergency contact: Name _____

Phone number _____

Referred by _____

Your current or past occupation_____

What are your most important self care practices? _____

_____

_____

What hobbies do you enjoy? _____

_____

_____

How is your sleep? _____

How many hours do you typically sleep each night? _____

What is your usual physical activity? _____

_____

**Women :** Are you or might you be pregnant? NO YES / Weeks _____

**Skin Care Questions :**

What are your expectations for the service you are receiving today?_____

_____

_____

_____

_____

What 3 things do you love about your skin?

_____

_____

_____

What 3 things would you like to change about your skin?

_____

_____

_____

Do you currently or have you used or had:

Do you use Retin-A, Renova / vitamin A derivative products ? Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? NO YES

Botox, Juvederm, or another injectable? NO YES

Acne medication? NO YES, when?_____Which drug?_____

Chemical peel or microdermabrasion? NO YES

Tanning bed? NO YES

Have you used these products in the last 3 months? NO YES _____

If YES to any of these, please explain: _____

_____

Have you ever experienced claustrophobia? NO YES

Do you have any known allergies to anything you have used on your skin? NO YES, describe:_____

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

rash irritation peeling sun sensitivity breakout

Other / explain:_____

Have you had cosmetic surgery? NO YES, describe: _____

_____

What products are you currently using on your skin? List brand and circle **S for satisfied** and **U for unsatisfied**.

Cleanser S / U _____ Toner S / U _____

Moisturizer S / U_____ Sunscreen S / U _____

Mask S / U _____ Foundation/ makeup S /U_____

**Medical History**

Are you currently under the care of a doctor, dermatologist or other health care practitioner? NO YES

If yes, for what condition?

_____

_____

Name of practitioner/clinic

_____

City _____ State _____ Phone_____

List any medications you are taking:_____

_____

_____

Are you using any photosensitizing drugs? NO YES ; describe_____

Do you have allergies to: Shellfish, Aspirin, Nuts, Honey

Foods_____

Other known allergies_____

**Do you have a history of cancer? NO YES** **If yes, please answer the following:**

Type _____

Chemotherapy? NO YES, type _____

When? _____ Completed? _____

Radiation therapy? NO YES, where? _____

When? _____ Completed? _____ Radiation burns?_____

Surgery? NO YES, where?_____

Lymph nodes removed? NO YES, where and how many? _____

Lymphedema? NO YES, location / side _____

Are current blood counts a concern? NO YES : If yes, describe _____

_____

**Medical Continued:**

Do you currently have:

Acute inflammation - caused by an antigen - bacteria, viruses or poisons? NO YES

Acute Phlebitis - inflammation of the vein, past or present? NO YES

Acute Thrombosis, past or present? NO YES

Congestive heart problems, past or present? NO YES

If yes to any of the above, please explain: _____

_____

Is there anything else you would like me to know? _____

_____

_____

## Cancellation Policy and Liability release:

I understand that payment is due at the time of treatment unless arrangements have been made otherwise. I agree to give at least 24 hours notice of cancellation of an appointment and I understand that if I give less than 24 hours notice I may be charged the full amount of the appointment booked. Cases of extreme emergency are considered exceptions to this cancellation policy.

I have given an accurate account of the questions asked above including all known allergies, prescription drugs or products I am currently ingesting or using topically. I take it upon myself to keep Nissa updated on my health.

I agree to release, save, hold harmless and indemnify Nissa Valdez and Ritual Self Care LLC, its officers, directors and employees from and against any future claims, demands or legal actions arising out of any session I receive at or through Ritual Self Care LLC. I specifically understand that I am agreeing that neither I nor my family will make any future claims or demands on and further not to sue or take legal actions against my therapist nor against Ritual Self Care LLC, its officers or directors for negligence, strict liability, malpractice, breach of contract or for any other legal cause of action which may arise from any session I receive through Ritual Self Care LLC.

By signing this document I am stating the following: (1) I am able to read, understand and comprehend the English language; (2) I have carefully read the provisions contained in this document; (3) I understand, comprehend and agree to the provisions contained in this document.

**Client's Printed Name** _____

**Client's Signature**_____ **Date**_____

**Parent / Guardian Signature if client is under 18 years old** _____