FACE TECHNIQUES

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Birth date:

Address:
City/State:
Zip:

Home phone no.:	Cell phone:	Email:
Occupation:	Confirmation Method: Phone:___ Email:____	

HEALTH HISTORY

Pregnant or planning to become pregnant in next 3 months	Yes No	Tobacco use	Yes No	Alcohol use	Yes No
High blood pressure	Yes No	Bleeding tendencies	Yes No	Seizures	Yes No
Cancer	Yes No	Heart Disease	Yes No	Diabetes	Yes No
Asthma	Yes No	Neuromuscular disorders	Yes No	Stroke or paralysis	Yes No
Hepatitis	Yes No	HIV	Yes No	Thyroid conditions	Yes No
Raynauds	Yes No	Impaired Circulation	Yes No	Blood Clots	Yes No
Varicose Veins/enlarged blood vessels	Yes No	Shingles	Yes No	Cold Sores	Yes No
Cryoglbulinemia	Yes No	Cold Hemoglobinuria	Yes No	Keloid or unusual scar formation	Yes No
Skin diseases	Yes No	Rosacea/flushing of the skin	Yes No	Acne	Yes No
Pregnancy or hormone related increase in pigment	Yes No	Increased pigment following injury	Yes No	Glaucoma or eye disease	Yes No
Migraines/Frequent Headaches	Yes No	PCOS	Yes No	Implanted devices	Yes No
Contact lenses	Yes No	TMJ	Yes No		Yes No
Any other serious illness?	Yes No	Under a physicians care for any reason?	Yes No		

If you answered "yes" to any of the above, please explain:

Date:
Name:
DOB:

Patient Registration Page 2

Medications, Herbal Supplements and Vitamins:	Allergies:

Have you ever been treated for:

		If "YES", what type of treatment did you have? (laser, Botox, etc)			If "YES", what type of treatment did you have? (laser, Botox, etc)
Acne	Yes No		Skin texture or scars	Yes No	
Brown Spots	Yes No		Skin Laxity	Yes No	
Enlarged blood vessels	Yes No		Unwanted Hair	Yes No	
Fine lines and wrinkles	Yes No		Fat Reduction	Yes No	
Rosacea/flushing of the skin	Yes No			Yes No	

Massage:

Have you had a recent injury? If so, what?______________________

Do you have regular massage? If so, how often?_________________

When having a massage what is your pressure preference?________

Date:
Name:
DOB:

Patient Registration Page 3

SKIN TYPE

Please check box that best describes your skin when exposed to the sun for one hour with no protection:

- Always burns, never tans ☐
- Always, burns, sometimes tans ☐
- Sometimes burns, always tans ☐
- Rarely burns, always tans ☐
- Brown, moderately pigmented skin ☐
- Black Skin ☐

What nationality(s) are your grandparents?____

Do you use (or have you used) a tanning bed? If so, when?__________________________________

Do you use a self-tanner? If so, when?____

We take patient confidentiality seriously! Your information will not be shared without your prior written consent.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that results may vary and there is no guarantee I will be able to my desired results.

Patient/Guardian signature ______________________ Date ______________