Health and Cosmetic Questionnaire

CLIENT DEMOGRAPHICS

First Name_____Last Name_____Date of Birth (mm/dd/yyyy) ___/___/_____

Gender_____Height_____Weight_____Waist_____

Address _____ City_____

State_____Zip_____ ___Country_____

Cell Phone _____Work Phone _____Home Phone _____

Email Address_____

Occupation_____

How Did You Hear About Us?_____

EMERGENCY CONTACT INFORMATION

First Name_____Last Name_____Phone _____

Relationship_____

PRIMARY CARE PHYSICIAN

First and Last Name_____

Primary Office Phone _____

WELLNESS INFORMATION

Please indicate your daily consumption of the following: (place a number value that represents the average daily intake)

_____Tobacco_____Alcohol _____Caffeinated Beverages _____Water (8oz glass)

Do you exercise? _____How often and what type? _____

FOR WOMEN

Are you pregnant or planning a pregnancy in the next 3 months? _____

Are you using hormonal contraception?_____

Are you undergoing hormone replacement therapy (HRT)?_____

Are you perimenopausal or menopausal?_____

FOR MEN

Are you a professional athlete? _____

Are you undergoing hormone replacement therapy (HRT)?_____

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MEDICAL HISTORY

Please check the items below that you currently have or have had a history of

A. SKIN PROBLEMS

- ❑ Cold Sores
- ❑ Vitiligo
- ❑ Cystic Acne
- ❑ Developing Keloids
- ❑ Accutane
- ❑ Skin Cancer
- ❑ Eczema
- ❑ Atypical Moles
- ❑ Retin-A
- ❑ Rosacea
- ❑ Melanoma
- ❑ Photosensitivity
- ❑ Skin Related Autoimmune Disease
- ❑ Fresh Scars or Wounds
- ❑ Vitiligo
- ❑ Burns
- ❑ Psoriasis
- ❑ Broken Facial Capillaries
- ❑ Facial Sores or Eruptions
- ❑ Russian Threads
- ❑ A Very Dry and Fragile Skin

B. CHRONIC CONDITIONS

- ❑ Diabetes
- ❑ Heart Conditions
- ❑ Hypertension
- ❑ Arthritis
- ❑ Thyroid Problems
- ❑ Sinus Problems
- ❑ Fibromyalgia
- ❑ Multiple Sclerosis
- ❑ Asthma
- ❑ Chemotherapy
- ❑ Liver and/or Intestine Disease
- ❑ Lupus
- ❑ Scleroderma
- ❑ Rheumatoid Arthritis
- ❑ Blood Transfusions
- ❑ Emphysema
- ❑ Chest Pain

C. MENTAL HEALTH

- ❑ Depression
- ❑ Fainting (
- ❑ Epilepsy / Seizures
- ❑ ADHD
- ❑ Headaches

D. INFECTIOUS CONDITIONS

- ❑ Hepatitis
- ❑ Drug-Resistance
- ❑ C. difficile
- ❑ Herpes
- ❑ HIV / AIDS
- ❑ Inflammation

E. CARDIO - VASCULAR AND BLOOD DISORDERS

- ❑ Blood Thinners Use
- ❑ Phlebitis
- ❑ Varicose
- ❑ Bleeding Problems
- ❑ Bruise Easily
- ❑ Spider Veins

F. IMPLANTS / GRAFTS / MEDICAL DEVICES

- ❑ Internal Defibrillator / Pacemaker
- ❑ Silicon Implants
- ❑ Organ Transplant
- ❑ Superficial Metal Implants
- ❑ Dental Implants /Veneers
- ❑ Contact Lenses
- ❑ Cups

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MEDICATION LIST

Please list all medications that you are currently taking or have used in the past 6 months

MEDICATION	AMOUNT	FREQUENCY

Please list all Naturopathic, Health Food Supplements, Vitamins, and Probiotics

_____

_____

Please list ALL ALLERGIES including LATEX

_____

_____

Have you or anyone in your family ever had, or currently have a history of unusual reactions or problems with TOPICAL anesthesia (e.g. anesthetic creams or gels) resulting in rushes, muscle weakness, jaundice, breathing problems, and/or unexpected fever(s)?

_____YES_____NO

COSMETIC FACIAL AND BODY TREATMENTS IN THE PAST

_____ Chemical Peels
_____ Fillers
_____ Microdermabrasion
_____ Facial Surgery
_____ Kybella
_____ Photorejuvenation (IPL)
_____ Cool- Sculpting
_____ Lymphatic Drainage
_____ Laser Tattoo Removal
_____ Facial Masks
_____ Botox
_____ Micro-needling
_____ Retin A / Renova
_____ Facial Lasers
_____ Radio Frequency Lift
_____ Hair Removal
_____ Liposuction
_____ Body Endermologie
_____ Laser Skin Tightening
_____ Spider Veins Removal

EXPOSURE TO THE SUN AND SELF TANNERS

Do you use self -tanners?_____

Did you have sun exposure in the last month? _____

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AREA(S) OF CONCERN

Please check your top ten areas of concern

A. FACE / NECK / DECOLLETE

_____ Wrinkles	_____ Saggy Skin	_____ Loose Eye Contour
_____ Dark Circles	_____ Fine Lines	_____ Enlarged Pores
_____ Face Contour	_____ Dull Skin	_____ Age Spots
_____ Sun Damage	_____ Scars	_____ Unwanted Hair
_____ Uneven Texture	_____ Lips Contour	_____ Rosacea
_____ Post-acne scars	_____ Double Chin	_____ Thinning Lips
_____ Puffiness	_____ Dry Skin	_____ Under Eye Bags
_____ Hyper-pigmentation		

B. BODY / ARMS / LEGS

_____ Enlarged Upper Back	_____ Enlarged Love Handlers
_____ Enlarged Arms	_____ Enlarged Legs
_____ Enlarged Abdomen	_____ Saddlebags
_____ Post-operative scars	_____ Stretch-marks
_____ Cellulite	_____ "Heavy" Legs
_____ Uneven Post-Liposuction Skin	_____ Sun Damage
_____ Saggy Skin on Hands	_____ Saggy Skin on Knees
_____ Saggy Skin on Ankles	_____ Edema
_____ Minor Muscle Pain	_____ Sun Damage
_____ Lymphedema	_____ Hyper-pigmentation
_____ Excess of Fluids	

I acknowledge that I have disclosed my complete medical history and the above is a complete and accurate representation of my medical, psychological, and cosmetic status. I represent to the staff that I am at least 18 years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize a history examination by staff as may be assigned by him/her.

I authorize the taking of photographs. These photographs will be used solely for documentation purposes and will be kept confidential unless otherwise disclosed.

I understand that there is a consultation fee for the evaluation appointment unless other arrangements have been made in advance.

Signature:_____ Date:_____

Relationship: _____

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Acknowledgment of Practice Policies

I understand that I will receive traditional spa or cosmetic medical treatment from the Valeriya Life. I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment. _____(Please Initial).I am fully aware that my condition is solely of a cosmetic nature and that the decision to procedure is based on my expressed desire to do so:_____(Please Initial).

Payment Policy
I understand that my treatments at Valeriya Life require payment and the prices and fee structure for treatment have been explained to me. I understand that the services often require more than one session for best outcome, and I have the option of purchasing a series/package of treatment sessions at the quoted package price. There is no guarantee of refunds on treatments paid in advance. I agree to pay for the treatment according to the payment plan discussed._____(Please Initial).

Cancellation and Late Policy
I am aware that Valeriya Life requires 24 hours notice of a cancelation and that it is my responsibility to provide timely notice by calling Valeriya Life. I agree to pay a $50 fee if I fail to give the required 24 hours notice. If I have paired my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide Valeriya Life with the required 24 hours notice. _____(Please Initial).

Return Policy
All sales of skin care/makeup products and vitamins/supplements may be returned with a receipt for a credit within 30 days. _____(Please Initial).

Disclaimer
I understand that all medical cosmetic treatments are provided exclusively by Valeriya Life. I will not hold Valeriya Life, it's owners or its employees responsible for the results I experience. I realize that results may vary. I further understand that Valeriya Life cannot prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion._____(Please Initial). I understand that even with the best technology and highest trained technicians, some patients will not have a desired response/ outcome to treatment._____(Please Initial).

Pictures for Before-After Outcome Assessment
I understand that for treatment plan staff will take picture of my face and/or body before, during, and after treatment for tracking my progress.

Privacy
I have received a copy of Valeriya Life Notice of Privacy Practice. I have read and fully understand all the terms of this Acknowledgment of Practice Policies, all my questions have been answered to my satisfaction and I agree to the terms of this consent:
Print Patient Name:_____

Patient Signature:_____Date_____

I have explained the above statements to the client and answered all questions.

Print Staff Name:_____

Staff Signature:_____Date:_____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA began on April 14, 2003. There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with our company services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

Our practice has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your cosmetic care are handled appropriately. This specifically includes the sharing of information with other wellness providers, health insurance payers if this is necessary for your financing and care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, procedure rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services. We may utilize aggregate patients' information for analysis for quality assurance.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____(Print Name) hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Patient Signature:_____ Date_____

Witness (Print): _____

Witness Signature:_____

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