Spa Client Medical History Questionnaire

Full Name

Date of Birth

Phone Number

Email Address

Address

Emergency Contact Name

Phone Number

Medical History
Do you have any current medical conditions?

Are you allergic to any products or ingredients?

Are you currently under the care of a physician?

Yes No

List any medications you are currently taking

Skin concerns or goals

Lifestyle Information

Do you smoke?

Yes No

Do you drink alcohol?

Yes No

How often do you exercise?

Any other information you wish to share