GREENWAVE
FAMILY WELLNESS CENTER

215 Forest Park Circle Panama City, FL 32405 *Office 850-215-5657

CONFIDENTIAL SKIN HEALTH SURVEY

(For Frida Natural Dermabalance)

Name: _____ Date of Birth: ____/____/____ Intake Date: ____/____/_____

Address: _____
_____
_____

Home Phone (____) _____
Cell Phone (____) _____
Work Phone (____) _____

Your Occupation _____

Employer: _____

Emergency Contact-Name: _____
Address: _____

Relationship: _____
Phone (____) _____

Who referred you to this office? _____

Please list your current Dermatologist/Physician: _____

Please provide a brief explanation of your reason for today's visit and any concerns you may have:
_____
_____
_____

IF APPLICABLE, CIRCLE ANY SKIN CONDITIONS/ISSUES YOU WISH TO ADDRESS:

Esthetic concerns:	**Dermatology:**	**Pregnancy:**	**Pre/Post Surgery:**
• Wrinkles • Saggy Skin • Dry Hematosis (bags under the eyes) • Cellulite • Breast Ptosis (Sagging Breasts) • Hyper-pigmentations (Dark spots) • Hyper-pigmentations (Light spots)	• Acne • Rosacea • Psoriasis	(Starting at four months) Gentle treatment of the body throughout the process • Skin conditioning • Stretch mark prevention • Breast conditioning and shape support • Post Birth Recovery and Toning	(face lifting, cesarean and others) • Prepare the tissue for the intervention to help the scaring process and relax the mind and body • Detoxification • Help the scaring process

SKIN HEALTH SURVEY (Continued)

Is this your first facial? Yes No If yes, how long ago was your last skin treatment? _____

Have you had a Chemical Peel or Microdermabrasion? Yes No
Please describe _____

Do you have Acne? Yes No Hyper-pigmentation? Yes No Hypo-pigmentation? Yes No

Rossacea? Yes No Keloids (thick scars)? Yes No Where? _____

Do you have any other skin conditions? _____ Yes No
If yes, please explain: _____

Do you experience frequent blemishes? _____ How frequently? _____

Do you have any allergies to food, herbs, plants, trees, seafood, cosmetics or drugs? Yes No
Please list_____

Are you presently taking medications (oral or topical)? Yes No
Please list_____

Are you Pregnant or Lactating? Yes No

Are you taking birth control pills? Yes No What type? _____

Are you taking hormone replacements? Yes No What type? _____

Do you wear contact lens? Yes No

Do you smoke? Yes No

Daily fluid intake (glasses/day) Water ____, Coffee/Tea ____, Soft Drinks ____, Alcoholic Drinks ____

How would you rank your level of general stress experienced (1 Low to 10 High)? _____
Please describe _____

Are you currently involved in a fitness program? Yes No
Please describe _____

Have you had any type of cancer? Yes No
Please describe _____

SKIN HEALTH SURVEY (Continued)

Please circle any that you are currently using or have used:
(Azelex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alphahydroxy acid)
Please describe usage history _____

Are you presently under a Physician's care for any current skin condition or problem? Yes No
Please describe _____

Please mark if you are affected by or have any of the following:

Asthma	_____	Hysterectomy	_____
Cardiac Problems	_____	Immune disorders	_____
Diabetic	_____	Hypo/Hyper thyroid	_____
Epilepsy	_____	Metal bone, pins	_____
Fever blisters	_____	Pacemaker	_____
Headaches-chronic	_____	Psychological problems	_____
Hepatitis	_____	Sinus problems	_____
Herpes	_____	Urinary or Kidney problems	_____
High blood pressure	_____	Varicose Veins/Swollen legs	_____
Law blood pressure	_____	Bad digestion or constipation	_____

Please explain above problems or list any health concern: _____
_____
_____

I understand that the information herein is to aid the Skincare specialist in giving better service and is completely confidential.

Skin Care Policies:

1. We require a 24-Hour cancellation notice or a cancellation fee of $50 is due.
2. Joining a Green Wave wellness plan does qualify you for a 10% discount off of services.

I fully understand to the above Green Wave/Frida policies.

_____ _____

Client's signature Date

GREENWAVE
FAMILY WELLNESS CENTER

215 Forest Park Circle Panama City, FL 32405 *Office 850-215-5657
(For Frida Natural Dermabalance)

Skin Health Treatment Consent and Release

I acknowledge that the practice of massage and nail, hair, and skin care treatments including microblation, microdermabrasion, electrolysis, facials, body treatments, facials, toning, TPR treatments, laser treatments, and various other beauty treatments are not an exact science and no specific guaranties can or have been made concerning the expected result. I understand that some clients experience more change and improvements to become apparent than others.

I also realize that the following risks and hazards may occur in connection with any particular treatment including but to limited to: unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring, change in the skin pigmentation, and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. I also agree to hold harmless and release liability for Green Wave Family Wellness Center and Frida natural Dermabalance as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown that may arise as a result of any treatment that I receive.

Client's Signature	Print Name	Date