Date ____/____/____

mira
MED SPA

Client Information:

Name _____
Cell Phone _____ Email _____
Address _____ City _____ State _____ Zip _____
Single _____ Married _____ Date of Birth _____ Occupation _____
Referred by _____
Additional Information _____

Medical Information: check all that apply

☐ Pregnant	☐ Birth Control	☐ Hormone Replacement	☐ Smoker
☐ Oral Antibiotic	☐ Topical Antibiotic	☐ Steroids	☐ Asthma
☐ Neck/Back Pain	☐ Headaches	☐ Migraines	☐ Seasonal Allergies
☐ Latex Allergy	☐ Peanut Allergy	☐ Iodine Allergy	☐ Aspirin Allergy
☐ Hypertension	☐ Heart Disease	☐ Pacemaker	☐ Metal Plates, Pins
☐ Diabetic	☐ Prone to Cold Sores	☐ Epilepsy	☐ Herpes
☐ Rashes/Hives	☐ Shingles	☐ Bursitis	☐ Skin Cancer
☐ Rosacea	☐ Use Retinol	☐ Use Tazorac	☐ Use Accutane
☐ HIV/AIDS	☐ Hepatitis C		

☐ Currently under physician's care _____

Daily Home Regimen: check all that apply

☐ Facial Soap	☐ Facial Cleanser	☐ Toner	☐ Moisturizer
☐ Masque	☐ Eye Products	☐ Exfoliator/Scrubs	
☐ Sunscreen Daily	☐ Sunscreen Recreationally		

Are you currently using products that contain any of the following ingredients?

☐ Glycolic Acid	☐ Lactic Acid	☐ Vitamin A Derivatives	☐ Hydroxy Acid

Skin Concerns: check all that apply

☐ Premature Aging	☐ Sun Damage	☐ Wrinkles	☐ Texture/Tone
☐ Pigmentation	☐ Acne	☐ Flushing/Redness	☐ Pore Size

When out into the sun do you?

☐ Sometimes Burn	☐ Rarely Burn	☐ Very Rarely Burn	☐ Never Burn

I understand that the use of certain medications and over-the-counter products can significantly increase the risk of adverse reactions and/or injury. I hereby confirm that I am not using any medication that may cause or contribute to any such reaction/injury and I will advise my therapist should I use any such medication in the future. I understand that there are inherent risks associated with skincare services and I agree that as a condition of providing these services on an ongoing basis I will not hold Mira Med Spa responsible should there be any unfavorable outcome or result.

Client Signature _____ Date ____/____/____

Therapist Signature _____ Date ____/____/____