Sonata Spa **Confidential Case History # _____**

Name_____ Birth Date_____

Address_____City_____State_____Zip_____

Occupation_____ Drivers License#_____

Home Phone_____Cell/Text Phone_____e-mail: _____

How were you Referred? ____Person_____Person's Name_____Yellow pgs____Other_____

Is your family aware that you are receiving treatment? ____Yes____No Emergency Contact _____

Skin Care Concerns_____

Desired Treatment

Acne, Black/White heads	Dry, flaky skin
Premature aging	Oily skin
Sun damage, Pigmentation, Aging spots	Skin rejuvenation

Are you currently under a physician's care? YES [ ] NO [ ] GYN [ ] DERMATALOGIST [ ] FAMILY [ ]
Physician's name and address_____

Medical History

	YES	NO
Acne	[ ]	[ ]
Allergies	[ ]	[ ]
Canker sores	[ ]	[ ]
Contact Lenses	[ ]	[ ]
Cold Sores/Herpes	[ ]	[ ]
Cancer	[ ]	[ ]
Dermatitis	[ ]	[ ]
Diabetes	[ ]	[ ]
Hepatitis	[ ]	[ ]
Heart Condition	[ ]	[ ]
Pace Maker	[ ]	[ ]
Seizures	[ ]	[ ]
Metal Pins in Body	[ ]	[ ]
Surgery	[ ]	[ ]

	YES	NO
High Blood Pressure	[ ]	[ ]
Hemophilia	[ ]	[ ]
H.I.V. Tested	[ ]	[ ]
Keloid Scars	[ ]	[ ]
Moles	[ ]	[ ]
Warts	[ ]	[ ]
Females only condition:		
Menopause(current)	[ ]	[ ]
Post Menopause	[ ]	[ ]
Pregnant	[ ]	[ ]
Hysterectomy	[ ]	[ ]
Hormonal Imbalance	[ ]	[ ]
Irregular Periods	[ ]	[ ]
I.U.D.	[ ]	[ ]

Allergies/ Sensitivities	YES	NO
Topical- Local	[ ]	[ ]
Alcohol	[ ]	[ ]
Aloe Vera	[ ]	[ ]
Anesthetics	[ ]	[ ]
Cosmetics	[ ]	[ ]
Sea Breeze	[ ]	[ ]
Latex Gloves/Powder	[ ]	[ ]
Food	[ ]	[ ]
Sun	[ ]	[ ]
Soaps	[ ]	[ ]
Other:		

Current Medications	**Type & Dosage**
Birth Control Pills	[ ] _
Cortisone	[ ]
Hormones	[ ]
Dilantin	[ ]
Minoxidil	[ ]

Other:_____

Skin Care History

Current Skin Treatment	**Yes**	**No**	**Application**
Accutane	[ ]	[ ]	_____
Glycolic Topical/Peel	[ ]	[ ]	_____
Retin-A/Renova	[ ]	[ ]	_____
Botox/Other injections	[ ]	[ ]	_____
Facials	[ ]	[ ]	_____
Microdermabrasion	[ ]	[ ]	_____
Artificial Tanning	[ ]	[ ]	_____
Other _____			

Current Skin Care Products Brand Name /Routine

Cleanser _____ Morning _____Evening_____
Toner_____ Morning _____Evening_____
Moisturizer _____Morning _____Evening_____
Scrub _____Daily _____Weekly_____
Other_____
_____

Do you have any unusual skin condition? _____
Do you have healing problems? IF yes, explain _____
Previous Skin Treatments: _____Date started: _____
Describe any manifestation of prior treatment on skin? _____
What are your expectations of the Treatment? _____

Informed Consent

_____I acknowledge that all information contributed by me is accurate to the best of my knowledge, and that the present condition of the areas to be treated is as stated on this record.
_____ I have been advised of the post-treatment healing process, possible risks related to treatment.

Parental Consent

I_____ Parent of _____give my permission to treat her/his skin

Signature _____Date_____