# Cristabel Spa & Wellness

New Client Form

## Welcome to our treatment room!

Please feel free to ask any questions at any time. We look forward to a healthy relationship with you and your family.

Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female
Street: _____ Apt: _____
City: _____ State: _____ Zip: _____
Home Telephone: _____ Mobile Telephone: _____
Occupation: _____ Student ☐ Veteran/Military ☐
Email Address: _____
Emergency Contact: _____ Relationship: _____ Telephone: _____

**FAMILY SURVEY**

Relationship Status: ☐ Single ☐ Married If married, anniversary date: _____

Children? ☐ Yes ☐ No If yes, how many? _____
At CSW we are not only interested in your health and wellbeing but also of your family and loved ones. Does anyone in your immediate family have any skin concerns? ☐ Yes ☐ No
If yes, please detail: _____

**LIFESTYLE HABITS**

How many times per week do you exercise? ☐ Never ☐ 1-2 ☐ 3-4 ☐ 5+
What do your daily work habits include? (i.e. sitting, standing, light labor, heavy labor, computer work):
_____

How would you rate your eating habits? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How many glasses of water do you drink per day? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ 8-10 ☐ 11+
How often do you eat fresh fruits and vegetables per day? _____
On a daily basis, what do you eat:
For breakfast? _____
For lunch? _____
For dinner?_____
For snacks? _____
What vitamins and nutritional supplements do you currently take?
_____

Do you smoke? ☐ Yes ☐ No How much per day? _____
How often do you consume alcohol on a weekly basis? _____
How much coffee or caffeinated beverages do you consume on a daily basis? _____
How many hours of sleep do you get per day/night? _____

How many bowel movements do you have per day? ☐ 0 (how many per week: _____) ☐ 1 ☐ 2+
Are there any other health habits to share with us? _____

**PRIOR SKIN CARE TREATMENT INFORMATION**

When was your last facial? _____ When was your last skin exam? _____
Name/Location of Skincare Therapist: _____
Name/Location of Dermatologist: _____
What skin care line and products are you currently using? -
_____
_____
Do you use sunblock? _____ If not, why? _____
Do you wear makeup? _____ What kinds and brand? _____
Do you wax facial skin on a regular basis? _____ If so, when was the last time? _____

Have you ever had a facial, peel, microdermabrasion, laser or any resurfacing treatments? ☐Yes ☐No
If yes, when? _____

Are you using? ☐ Accutane ☐ Retin-A ☐ Benzoyl Peroxide

**ADDRESSING ISSUESTHAT MAY HAVE BROUGHT YOU HERE**

If you have NO skincare concerns/issues and are here solely for wellness, pampering, and to maintain your skin, check here: _____
If you have skin care concerns/issues, please list them here:
_____
When did you first develop the concerns/issues? _____

Is the condition getting worse, getting better, or staying the same? _____
Where specifically are your concerns/issues located (if not already mentioned?_____
Rate the level of your concern (1, just an observation to 5, affects my confidence/daily activities): [ 1 2 3 4 5 ]
What treatment have you already tried for your concerns/issues?
_____

**SKIN HEALTH HISTORY**

Have you been treated for: ☐Acne ☐Depression ☐Skin Disease ☐High Blood Pressure ☐Cold Sores ☐Diabetes

☐Cancer ☐Circulatory Issues ☐Hormonal Imbalances ☐Recent Surgery ☐Pregnant ☐ Chemotherapy ☐Arthritis

☐Hysterectomy ☐Thyroid ☐Pregnant or Trying to get Pregnant?

List all medications: _____

☐Accutane ☐Antibiotics ☐Birth Control

List all allergies/sensitivities:_____

Circle Your Current Level Of Stress: 1 2 3 4 5

Circle Your Normal Level Of Stress 1 2 3 4 5

Does your job/lifestyle require you to work/play outdoors? _____ Your last sunburn? _____ Use tanning beds? _____

When you go out into the sun, do you (check one):

☐Always Burn (I) ☐Usually Burn (II) ☐Sometimes Burn (III) ☐Rarely Burn (IV) ☐Very Rarely Burn (V) ☐Never Burn (VI)

Have you ever been under the care/treatment plan of a:

☐ Dermatologist ☐ Plastic Surgeon ☐ Aesthetician ☐ Are you interested in cosmetic surgery?

Circle how you feel about the overall quality of your skin: (Bad) 1 2 3 4 5 (Fantastic)

What do you think your skin type is (check one): ☐Normal ☐Dry/Dehydrated ☐Oily/Acne Prone ☐Combo ☐Sensitive/Rosacea

What are your main skin care goals?

_____
_____
_____

I have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive are voluntary and I release Cristabel Spa & Wellness and/or skin care professional from liability.

Signature: _____ Date: _____

Thank you for completing this confidential questionnaire. This information will allow your professional skincare professional to provide the optimum products and services.