Name:	Date:	Occupation:
Address:	Phone:	Date of Birth:
City: State:	Zip Code:	Email:
Cell: Phone:	Contact me by __Text __Call	Emergency Contact:
How did you hear about us:		Referral Name:

General Health

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1
2. How many glasses of water do you drink per day? ____________ How much caffeine do you consume daily? _______________
3. Do you smoke? YES NO
4. How much UV exposure do you get? (tanning beds, sun, commuting in the car) _____________________________________
5. Please list any accidents or surgeries in the last 9 months:
6. Do you have any metal implants, pacemakers, body piercings?
7. Have you taken any oral or topical antibiotics within the past 6 months? ( ) Oral ( ) Topical / Name:_____________________

Prescriptions taken daily:	Over the Counter:

Health History:

Heart Condition	Cancer	Herpes/Shingles	High Blood Pressure	Low Blood Pressure
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	
Rashes	Jaw Pain/TMJ	Blood Clots	Constipation	
Diabetes	Gas/Bloating	Headaches	Arthritis	
Broken/Fractured Bones	Pregnancy (_______weeks)	Fatigue/Sleep Disorder	Depression/Anxiety	

Other (explain):

Skin Care:

1. Are you under the care of a dermatologist? YES NO
2. Do you use: Accutane Retin-A Renova Adapalene Other prescription skin products _____________________
3. How often do you exfoliate? ( ) Once a week ( ) Twice a week ( ) Once every two weeks ( ) Never
4. Are you currently using any products that contain: Glycolic Acid Lactic Acid Hydroxy Acid Vitamin A
5. Do you have any skin sensitivities or irritants?

Skin Care:
Products You Use: Soap Cleanser Toner Moisturizer Exfoliator Masque
Skin Type: Circle all that apply: Oily/Congested Dry/Dehydrated Sensitive/Redness Acne Normal
Do you suffer from any of the following? ( ) Acne ( ) Blackheads ( ) Whiteheads ( ) Milia ( ) Hyperpigmentation ( ) Scarring ( ) Eczema ( ) Cellulite ( ) Psoriasis ( ) Vein/Circulation Problems ( ) Age Spots
Have you ever received any of the following treatments: ( ) Facial ( ) Microdermabrasion ( ) Laser/IPL Surgery ( ) Chemical Peels ( ) Laser Hair Removal ( ) Radio Frequency
What are your skin care goals you hope to achieve?

It is my choice to receive these Services from BelleVi. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update the staff at BelleVi of any changes to my health status.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24hour notice, I agree to pay the missed appointment fee that applies.

Name ______________________ Date ______________________