



First Visit Date _____

Client Consultation

Name _____
Last First

Address _____ Apt./Unit _____

City _____ State _____ Zip _____

E-mail address: _____

Birth day _____ Anniversary _____
Month Day Year (Optional) Month Day Year (Optional)

Telephone: () _____ () _____ () _____
Home Business Cell

How did you hear about Ospa? _____

Referred by: _____

What would you like to achieve from your treatment today? _____

Your Health

(See next page for more space for answers)

1. Have you been in the care of a physician, dermatologist within the past year? no yes, explain: _____
2. Any recent surgery, including plastic surgery? no yes, explain: _____
3. Any skin cancer? no yes, please specify _____
4. Have you had any of these health problems in the past or present?
 cancer hormone imbalance systemic disease high blood pressure
 spinal injury thyroid condition hysterectomy diabetes
 heart problem varicose veins arthritis
5. Has your doctor discussed concerns about raising your body temperature? no yes, explain: _____
6. Do you smoke? no yes
7. Do you follow a restricted diet? no yes, please specify: _____
8. Do you follow a regular exercise program? no yes
9. List any medications you take regularly: _____
10. List your daily consumption of: Water _____ Caffeine _____ Alcohol _____
 no yes
11. Do you experience any problems sleeping? no yes
12. Do you wear contact lenses? no yes
13. Do you have any metal implants or wear a pacemaker? no yes
14. Have you had recent dental x-rays? no yes
15. Have you ever experienced claustrophobia? no yes
16. Do you suffer from sinus problems? no yes

Your Skin Care

- Have you ever had a facial treatment before? no yes, when? _____
- Have you ever had a body spa treatment before? no yes, what treatment, when? _____
- What temperature of water do you cleanse with? cool warm hot
- Do you have any special skin problems or concerns pertaining to your face or body? no yes, specify: _____
- Have you ever had chemical peels, laser or micro-dermabrasion? no yes
- In the last month? no yes
- Do you use Retin-A, Renova, Adapalene hydroxy acid or retinol / vitamin A derivative products? no yes, describe: _____
- Have you used these products in the last 3 months? no yes
- Have you used an acne medication? no yes, when? _____ which drug? _____
- What skin care products are you currently using? List brand where known
 soap _____ toner _____ mask _____ eye product _____
 cleanser _____ moisturizer _____ exfoliator _____ others _____

9. Please check any skin concerns that apply:

- Skin: break out/acne blackheads/whiteheads excessive oil/shine rosacea broken capillaries redness/ruddiness
 sun spot/liver spot/brown spot uneven skin tone sun damage wrinkles/fine lines dull, dry skin flaky skin
- Eyes: dehydrated wrinkles puffiness dark circles
- Lips: dehydrated cracked/chapped lips

10. Have you ever had an allergic reaction to any of the following?

- cosmetics medicine food animals sunscreens
 iodine pollen AHAs fragrance

Please specify _____

11. What SPF do you use on your face? _____ body? _____ Do you sunbathe? no yes
12. Do you burn easily in moderate sunlight? no yes
13. Have you ever experienced Botox? no yes

Female Clients Only:

1. Are you taking oral contraceptives? no yes _____
- Any recent changes? If so, what and when _____
- Are you pregnant? no yes Are you lactating? no yes
- Any menopause problems? no yes, please specify _____

Male Clients Only

1. What is your current shaving system? wet shave electric
2. Do you experience irritation from shaving? no yes Ingrown hairs? no yes

Have you started any new medications since your last visit?

Please describe: _____

Use this space to complete answers where space was insufficient. (Please include the number of the question.)

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. If I decide on a treatment against the advice of an Ospa professional based on my skin conditions or health history, I take full responsibility and will not hold Ospa liable.

Signature _____ **Date:** _____

