



History and Health Questionnaire

Client Information

First Name _____ Middle Initial _____ Last Name _____
 Date of Birth ____/____/____ Age _____ Wt. _____ Ht. _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell _____ Email _____
 Occupation _____ Employer _____
 Emergency Contact _____ Phone _____
 How do you prefer we confirm your appointments? Home Phone Cell Phone Email Do not contact me
 Do you wish to exclude yourself from all promotional emails and mailings? Yes No
 How did you hear about us? _____ Client: _____

General Medical Information

Please check (√) if you are affected by or have any of the following:

DIGESTIVE	SKIN	CHRONIC ILLNESSES cont.	CHRONIC ILLNESSES cont.
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Nausea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Edema	<input type="checkbox"/> Metal, pins, or plates	<input type="checkbox"/> Herniated Disc
<input type="checkbox"/> Acid Reflux	<input type="checkbox"/> Herpes/ Cold Sores	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Rosacea	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Heart Disease/Problem
<input type="checkbox"/> Colitis	<input type="checkbox"/> Cancer (Skin or Other)	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ulcers		<input type="checkbox"/> Urinary/ Kidney Problems	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> IBS		<input type="checkbox"/> Painful/Swollen Joints	<input type="checkbox"/> Blood clots/Phlebitis
<input type="checkbox"/> Celiac Disease	CHRONIC ILLNESSES	<input type="checkbox"/> Psychological Problems	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Lupus	<input type="checkbox"/> Pacemaker
	<input type="checkbox"/> Muscle Spasms	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Muscle Weakness
	<input type="checkbox"/> Myesthenia Gravis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Numbness
	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Lambert-Eaton Syndrome	<input type="checkbox"/> Vision/Eye Problems
	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> ALS	<input type="checkbox"/> Cholesterol

Please explain above problems or list any significant others: _____

■ List all medications, supplements, vitamins, diuretics, etc., that you are currently taking or have taken in the last 3 months:

■ List all allergies including cosmetics, foods, drugs, fragrance, etc.:

- Do you have an allergy to human Albumin? yes no
 - Do you have a sensitivity or allergy to Lidocaine? yes no
 - Do you have an allergy to beef? yes no
- Have you undergone surgery, cosmetic or otherwise? yes no

If yes, what type of surgery and how long ago? _____

Do you smoke? yes no If yes, how often? _____ Do you live with a smoker? yes no

Do you drink alcohol? yes no If yes, how often? _____

Are you, or might you be pregnant? yes no If yes, how far along? _____ Are you lactating? yes no

Are you taking birth control pills? yes no If yes, what kind? _____

Are you taking hormone replacement? yes no If yes, what kind? _____

Do you wear contact lenses? yes no

Rate your stress level on a scale of 1 to 5 (1= low stress, 5 = high stress). _____

Do you exercise? yes no If yes, how often? _____

How many 8 oz glasses of water do you consume each day? _____

Family Physician _____ Phone _____

Dermatologist _____ Phone _____

Skincare Information

Please check (✓) if you have used any of the following prescription skincare products in the last three months:

- Accutane Retin-A Renova Retinol Atralin Avita Tazorac Ziana Azelex Differin

Please explain how frequently you use the above products and list any other skincare prescriptions taken topically or orally:

Do you sun bathe or use tanning beds? yes no Do you use sunscreen? yes no Self-tanners? yes no

Do you sunburn easily? yes no Do you have a tendency to redness or flushing of the skin? yes no

Please check (✓) what you feel best describes your skin type (check all that apply):

- Normal Dry/Dehydrated Oily Combination Acne Prone Sensitive

What skincare products are you currently using?

Have you had any chemical peels, microdermabrasion, or any resurfacing treatments in the last month? yes no

If yes, which treatment and when? _____

Massage Information

Do you suffer frequently from stress? yes no

Have you had any accidents or injuries in the last two years? yes no If yes, explain. _____

Do you have tension or soreness in a specific area? yes no If yes, where? _____

Do you suffer from back pain? yes no Do you suffer from neck pain? yes no

Do you have numbness or stabbing pains anywhere? yes no If yes, where? _____

Are you sensitive to touch or pressure in a particular area? yes no If yes, where? _____

What type of massage pressure do you prefer? Light Medium Firm

Client Acknowledgment and Agreement

I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.

I hereby release and discharge Larimar Medical, PLLC and its employees and agents from any and all claims that I have or may have in the future in connection with my treatment relating to any and all procedures performed by them, regardless of the results.

I hereby authorize and consent to having photographs taken of me. I understand that they may be used as an aid for treatment purposes (including without limitation, documenting the progress of my treatment) and that any photographs taken will remain the property of Larimar Medical, PLLC. I further understand that using my photographs for any other purpose will require my signature on a different consent form and that my identity in those instances will be kept strictly confidential.

I hereby understand and acknowledge that Drs. Hunter Jennings, Robert Magill, and Jonathan Thompson, all local physicians with separate private practices, are the owners and Medical Directors of Larimar Medical, PLLC. In the event that I am a patient of one of these physicians through his separate private practice, I understand and acknowledge that I am free to seek medical spa services elsewhere if I am not comfortable with my physician's business interest in Larimar Medical, PLLC.

I hereby assume full responsibility for the payment of any and all services rendered by Larimar Medical, PLLC and will pay the full amount at the time of service, unless Larimar Medical, PLLC customarily bills insurance for a particular service. If Larimar Medical, PLLC bills my insurance for a particular service, then I authorize my insurance to pay Larimar Medical, PLLC directly for such service pursuant to the benefit terms of my insurance. I acknowledge and agree that I am ultimately responsible for any and all amounts that are not paid by my insurance. Furthermore, I acknowledge and agree that I am responsible for any collection agency costs, court costs, or attorneys' fees incurred by Larimar Medical, PLLC in collecting any outstanding balance for services rendered to me.

I hereby understand and acknowledge that Larimar Medical, PLLC is a facility that is supervised by Medical Directors who are NOT always on site during procedures.

Client Signature _____

Date _____