

Profiles Medical Customer Record Card
For all customers attending the salon

Please bring along to your appointment.

Name.....
Address.....
Tel Number day.....Night.....Mobile.....
Email.....
Fax.....
Occupation.....
D.O.B

Do suffer with any of the following

- Epilepsy
- Diabetes
- Any type of cancer or tumours
- Arthritis, Dermatitis or psoriasis
- Any Skin Allergies
- Any allergies
- Nut Allergies
- Blood disorders
- Thrush
- Haemophiliac
- Hepatitis
- Thrombosis or phlebitis
- Any Muscular problems or condition
- Hyper pigmentation
- Keloid Scarring
- Asthma, Hay fever or Rhinitis
- Pregnancy or recent pregnancy or planning a family
- High Blood pressure
- Low blood pressure
- Bowel disorders
- Cancer
- Disease
- Viral problems
- Fungal problems
- Breast problems
- Liver problems
- Kidneys problems
- Pancreatic problems
- Gall bladder problems
- Ears problems
- Sinus problems
- Allergies and allergic to anything
- Digestive problems
- Heart problems
- Bone problems
- Arthritis
- Migraines
- Sight problems
- Alopecia

- Skin complaints

How much water do you drink a day.....
How much alcohol units do you drink par day.....
How much sleep per night do you get.....
How much salt do you have in your diet

From 1 to 10 rates you stress levels. 1 being the lowest and no stress.....
How many children do you have.....
What are your children's ages

Do you have any nervous system disorders

Do you suspect you may be physically unwell in any way

Are you on any medication at present?.....

What birth control do you take/receive

Is there any possibility that you may be pregnant

Do you take any medication which is photo sensitive.....

How much water do you drink each day

Are you fit and well at present.....

Have you been in hospital or had any illness in the past five years

Have you had any form of cosmetic surgery in the past five years?.....

Name and address of Doctor.....

Have you ever recived treatment from a dermatologist.....

Are you taking any vitamins or multi vitamins or dietary supplements

Are you at present or in the last year had any of the following:

- Acid Peels of any type
- Chemical Peels
- Retinol / Retin A
- AHA's
- Laser Re surfacing
- Collagen / Restylene injections
- Botox
- Contraceptive (oral or injection)
- Antibiotics
- Tetracycline
- Herpes
- Accutane

Do you have any of the following?

Do you wear contact lenses

Do you wear glasses

What is your skin care routine.....

When did you last have a sun bed or sun exposure

Are you planning a holiday, if so please state when
Do you have regular sun beds or regular sun exposure

What are your concerns.....

I certify that the above statements are true and correct and I, having been advised and fully informed by my therapist of all the treatment contra indications. I understand any adverse reaction is not the fault of the therapist and I take full responsibility for the treatment that I receive. I have been informed the record cards are only for the use of the salon, salon promotional material, appointment confirmations, contact use all for the salon and the health department and insurance companies, my doctor; if every they are requested and I agree to my data being used by the above named for the capacities stated above.

Signature
Date
Therapist

Comments: