Style Essence

HISTORY FORM

Name: _____ Today's Date: _____

Date of Birth: _____/____/_____
Occupation_____

Are you presently under physician's care?_____

If so, for what? _____

_____

Previous experience with Infrared Therapy:

_____

_____

Primary reason for appointment. What do you hope to gain from your Infared Therapy? _____

_____

Please mark (X) all conditions that apply now. Put a P for past condition. Put an F for family history or illness.

____	Headaches, migraines	____	Chronic pain	____	Fatigue
____	Vision problems, contacts	____	Muscles or joint pain	____	Tension, stress
____	Hearing problems, deafness	____	Muscle, bone injuries	____	Depression
____	Injuries to face or head	____	Numbness or tingling	____	Sleep difficulties
____	Sinus problems	____	Sprains, strains	____	Allergies, sensitivity
____	Dental bridges, braces	____	Arthritis, tendonitis	____	Rash, athletes foot
____	Jaw pain, MJ problem	____	Cancer, tumors	____	Infectious disease
____	Asthma/lung condition	____	Spinal column disorders	____	Blood clots
____	Constipation, diarrhea	____	Diabetes	____	Varicose veins
____	Hernia	____	Pregnancy	____	High/low blood pressure
____	Birth control, IUD	____	Heart, circulatory problems	____	
____	Abdominal/digestive problems	____	Other medical conditions not listed		

Explain any areas noted above:

_____

_____

Current Medications, including Aspirin, Ibuprofen, Herbs, Vitamins, etc:

_____

_____

Surgeries:

_____

Accidents:

_____

Please list all forms and frequency of stress-reduction, activities, hobbies, exercise, or sports participation:

_____

_____

It is my choice to receive Infrared Therapy, and I give my consent to receive treatment. I understand that salon/spa practitioners are not trained in the diagnosis and treatment of disease. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. By signing this release, I do hereby waive and release the salon/spa practitioner from all liability, past, present, and future.

Signature:_____

Date: _____