

Vibrational Beauty Therapy Health History Questionnaire

Name _____	Phone: H _____	Birth date _____
Address _____	W _____	Occupation _____
_____	Cell _____	Referred by _____
E-mail _____	Emergency Contact _____	/ Phone _____

Please check conditions that apply (All information is confidential)

- ___ Allergies: To what? _____
- | | | | |
|--------------------|------------------------|-------------------------|------------------------|
| ___ Sinus problems | ___ Easily Bruise | ___ High Blood Pressure | ___ Anxiety |
| ___ Epilepsy | ___ Migraines | ___ Low Blood Pressure | ___ Depression |
| ___ Seizures | ___ Frequent Headaches | ___ Thyroid Disorder | ___ Insomnia |
| ___ AIDS/HIV | ___ Heart disease | ___ Herpes | ___ Hot Flashes |
| ___ Cancer | ___ Pacemaker | ___ Diabetes | ___ Digestive problems |

Skin Type:

- ___ Normal ___ Dry ___ Oily ___ Combination ___ Sensitive

Skin Conditions:

- ___ Acne ___ Eczema ___ Itching ___ Rashes ___ Rosacea ___ Skin Allergies ___ Skin Cancer

Habits:

- How much water do you drink/day? _____ How much coffee? _____
How much alcohol per day/week? _____ Smoke? No ___ Yes _____ #/day _____
How much sun exposure? _____
Exercise: Type _____ Frequency _____
Type _____ Frequency _____
Relaxation/Stress Relief:
Type _____ Frequency _____
Type _____ Frequency _____

Period/Menses/Menopause

- Are you currently pregnant? ___ Yes ___ No
Do you plan to become pregnant in the near future? ___ Yes ___ No

Please note menstrual problems _____
Please note menopause problems _____

What are your major facial concerns? _____

Other health concerns _____
