CLIENT QUESTIONNAIRE

Today's Date:___________________________________

Name:____ Date of Birth:____________________________

Medical Evaluation

List any medical conditions for which you are presently being treated?

____

____

Surgical History (Please list all operations)

Date	Operation	Date	Operation

Have you ever been treated by a physician at the Lindsay House?

- ☐ Yes
  Name of physician: ____
- ☐ No

Current Medications (Include vitamins, herbs, supplements)

Medication	Dosage

Are you allergic to any of the following?

Allergy	Yes	No	Description and Dosage
Medications			

Allergy	Yes	No	Please Indicate
Environmental			

Allergy	Yes	No	Please Indicate
Food (e.g. Seafood)			

Allergy	Yes	No	Please Indicate
Latex			

Allergy	Yes	No	Please Indicate
Tape			

Medical History

Please check the following conditions that apply to your medical history:

Condition	Yes	No	Condition	Yes	No
Cardiovascular	-----	-----	**Psychiatric**	-----	-----
Heart Attack			Anxiety / Depression		
Irregular Heartbeat			Claustrophobia		
High Blood Pressure			**Immune System**	-----	-----
Circulatory	-----	-----	Autoimmune Condition		
			Immunocompromised Condition		
Varicose Veins / Spider Veins			**Neuromuscular**	-----	-----
Blood Clot			Myasthenia Gravis		
Phlebitis			Seizures, Convulsions or Tremors		
Poor Circulation			Paralysis		
Swelling of Extremities			Multiple Sclerosis		
Pulmonary	-----	-----	Fibromyalgia		
Asthma			Spine or Back Disorder		
Shortness of Breath / Chronic Lung Disease			**Reproductive**	-----	-----
Pulmonary Embolism (blood clot)			Pregnancy		
Endocrine	-----	-----	Are you currently breastfeeding?		
Diabetes			Hormone Replacement Therapy		
Thyroid			Polycystic Ovaries / Ovarian Cysts		
Kidney or Bladder Disorder			**Liver / Hepatitis**		

Bleeding Disorder: ______ Self ______ Family member

Other Condition(s):

____

____

Nutrition

Are you currently dieting?

- ☐ Yes If so, what type? ____
- ☐ No

Social History

Do you smoke?

- ☐ Yes How many cigarettes per day? ____
- ☐ No

Do you drink alcohol?

- ☐ Yes How many servings per day? ____
- ☐ No

Do you exercise?

- ☐ Yes How often and what type? ____
- ☐ No

Skin

List skincare products currently using:

- ☐ Cleanser ______________________________
- ☐ Moisturizer ______________________________
- ☐ Eye Cream ______________________________
- ☐ Other ______________________________

Do you use any topical medications | creams prescribed by a physician (e.g. Retin-A)?

- ☐ Yes Please indicate: ______________________________
- ☐ No

Have you taken Accutane?

- ☐ Yes Please list last date of dose: ______________________________
- ☐ No

How often do you switch skincare products?

- ☐ Every 3 months or less
- ☐ Every year
- ☐ Never

Do you have or have you ever had any of the following?

Description	Yes	No	Description	Yes	No
Skin Cancer			Broken Capillaries or Flushing		
Pigmentation Problems			Acne		
Cold Sores			Accutane Use		
Keloids or Scarring			Steroid Therapy		
Difficulty Healing			Bruising		

Have you ever used a tanning bed?

- ☐ Yes Please list date of last session: ______________________________
- ☐ No

When is the last time you sunbathed? ______________________________

Do you regularly use a sunscreen?

- ☐ Yes If so, what kind? ______________________________
- ☐ No

Genetic Disposition (circle answers below)

Score	0	1	2	3	4
What is the color of your eyes?	Light Blue, Gray, Green	Blue, Gray, Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very Pale	Pale with Beige Hint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None

______ TOTAL Score for Genetic Disposition (to be completed by Service Provider)

Reaction to Sun Exposure (circle answers below)

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had a burn
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem

______ TOTAL Score for Reaction to Sun Exposure (to be completed by Service Provider)

Tanning Habits (circle answers below)

Score	0	1	2	3	4
When did you last expose your body to sun, artificial light, or tanning cream?	More than 3 months ago	2-3 months	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

______ TOTAL Score for Tanning Habits (to be completed by Service Provider)