MUSCLE MATTERS
Esthetics & Body Sugaring

CONFIDENTIAL HEALTH HISTORY FORM
3-276 Main Street Steinbach, MB R5G 1Y8
204-381-2729

First name:_____ Last name: _____

Address: _____ Mobile phone #:_____

City:_____ Home phone #:_____

Province:_____ Postal code:_____ Email: _____

Do you have a primary health care physician?
☐Yes ☐No

Emergency contact person: _____

Physician's name: _____ Emergency phone #: _____

Physician's phone #:_____ Relationship: _____

Physician's address:

How did you hear about us?

Please indicate any conditions you are experiencing, past or present.

ACCIDENT/INJURY

☐ Car Accident (Last 5 years)
Date:_____
Symptoms:_____
_____

☐Work/sport related
Date: _____
Date: _____
Symptoms:_____
_____

☐Whiplash:
Date: _____
Date: _____

☐Other:_____
_____

CARDIOVASCULAR

☐High/low blood pressure
☐Heart attack I Date:_____
☐Phlebitis/DVT
☐Stroke/CVA I Date:_____
☐Pulmonary emboli
☐Pacemaker
☐Heart disease
☐Angina
☐Varicose veins
☐Spider veins
☐Chronic congestive heart failure
☐Family history of any of the above

GASTROINTESTINAL

☐Irritable bowel syndrome (IBS)
☐Colitis
☐Gastroenteritis
☐Crohn's disease
☐Constipation/bloating
☐Other:_____

HEAD HISTORY

☐Tension
☐Migraines
☐Tooth/jaw/ear pain
☐Head trauma (ei: concussion)
Date:_____
☐History of headaches
Type:_____
☐Dizziness/fainting
☐Other:_____

RESPIRATORY

☐Chronic cough
☐Shortness of breath
☐Bronchitis
☐Asthma
☐Emphysema
☐Pneumonia
☐Sinus problems

OTHER CONDITIONS

☐Neurological condition
☐Epilepsy
☐Diabetes I Onset: _____
☐Allergies I Type: _____
☐Cancer I Type:_____
☐Family history of arthritis
☐Vision loss
☐Hearing loss
☐Insomnia
☐Hemophilia
☐Kidney/bladder problems
☐Dialysis
☐Overactive bladder
☐Osteopenia
☐Osteoporosis
☐Positional vertigo
☐Pins/wires/prosthetics
☐Medic alert bracelet
Specify:_____

MENTAL HEALTH

Indicate current stress level:
0 1 2 3 4 5 6 7 8 9 10
Not stressed Very stressed

☐Mental health disorder (anxiety, depression, ED, PTSD, etc.)
☐Other:_____
_____

INFECTIOUS DISEASE
☐Hepatitis
☐Infection/skin conditions
☐Tuberculosis
☐Aids/HIV
☐Herpes
☐Other:_____
_____

SKIN
☐Bruise easily
☐Athlete's foot
☐Rash I Type:_____
☐Warts
☐Skin tag
☐Eczema
☐Psoriasis
☐Other:_____
_____

CURRENT MEDICATIONS
_____
_____
_____
_____

DO YOU HAVE ANY OF THE FOLLOWING?
☐Open lesion/broken skin
☐Cyst, boil, pustule
☐New scars
☐Water retention (edema)

Are you currently on any blood thinners? ☐Yes ☐No

Have you taken Accutane in the past year? ☐Yes ☐No

Are you using Retin-A, Retinol, or Topical Vitamin C? ☐Yes ☐No

Are you using Lactic Acid, Glycolic Acid or Fruit Acids (AHAs)?
☐Yes ☐No

Are you using Lactic Acid, Glycolic Acid or Fruit Acids (AHAs)?
☐Yes ☐No

Have you had a chemical peel or microdermabrasion treatment?
☐Yes ☐No

Are you Pregnant? ☐Yes ☐No

RECENT SURGERY
(LAST 7 YEARS)
Date: _____
Type:_____
Date:_____
Type:_____

Current symptoms:
_____
_____

(IF RECEIVING RELAXATION MASSAGE)
AREAS OF CONCERN
☐Neck ☐Shoulders
☐Chest ☐Arms
☐Legs ☐Knees
☐Hips ☐Upper back
☐Mid back ☐Low back
☐Arthritis ☐Fracture

(BODY SUGARING ONLY)
Is this your first-time sugaring? ☐Yes ☐No
Your current hair removal method(s):_____

WARNING! *You may experience skin sensitivity from the following*:
➔Sunburn ➔Menstruation ➔Antibiotics ➔Pregnancy ➔Alcohol or caffeine

Please note that sugaring can have certain side effects such as skin removal, bruising, redness, swelling, tenderness, itchiness, etc.

☐ **I ACCEPT THESE TERMS**

(90 MINUTE FACIALS ONLY)
NOT for those who are pregnant, recently had a surgery, had Botox within the past 24 hours or those with metal implants. (e.g., pacemaker, screws, pins, staples, braces etc.)

☐ **I ACCEPT THESE TERMS**

Additional Information: *You can use this space to communicate any additional information such as preferred name, pronouns, triggers, concerns, etc.*

_____

_____

CANCELATION & NO-SHOW POLICY

Minimum of **24 hours** is needed to cancel or reschedule any appointments. Failure to do so will result in a fee.

10% service fee to cancel/reschedule within **24 hours**
30% service fee for **1st no show**
100% service fee for **2nd no show**

Will require full payment before rebooking any future appointments.

☐ I ACCEPT THESE TERMS

I have completed my medical history form as provided and disclosed to the esthetician and or sugarist my existing medical conditions and or any concerns. The information provided is true and complete to the best of my knowledge. I consent to be assessed and treated by my esthetician and or sugarist, using a variety of examinations and techniques, for the conditions noted in my health history. I understand that I may withdraw my consent to assessment and/or treatment. I intend this consent to cover the assessment and treatment discussed and will hold them harmless from any liability that may result from this treatment. I understand that all information gathered is confidential and that I must give consent for my health records to be released to Muscle Matters.

☐ I ACCEPT THESE TERMS

Patient Name: (Please print)_____

Patient Signature:_____Date:_____

Signature of parent/guardian (under 18):_____Date:_____

OFFICE USE ONLY