Patient Consult and History Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Wireless Provider (for confirmations): _____

Do we need to be discreet with messages? **Y** **N**

Email Address: _____

How did you hear about us? Please circle:

Family Savings **Facebook** **Google** **Drive-By**

Employee Referred **Social Media** **Other:** _____

Referred by another client (please give name so we may thank them):_____

Emergency Contact Information

Name: _____

Relation: _____

Phone: _____

Have you ever had an allergic reaction to any of the following?

Sulfur/Sulfa	Latex	Witch Hazel	Tea Tree
Grapes	Citrus	Fish/Marine/Iodine	Skin Allergy
Milk	Aspirin	Apples	

If yes, please explain: _____

Please list all medications currently being taken:

_____

Have you had any of the following in the last 14 days?

Facial Cosmetic Surgery	Botox Injections	Dermal Fillers
Light Treatments	Laser Resurfacing	Laser Treatments
Microdermabrasion	Other: _____	

Any problems with any of the listed procedures? **Y** **N**

If yes, please explain: _____

What topical medications or creams are you currently using? Retin A? Others?

_____

Have you ever used Accutane? **Yes No**

Do you currently have a sun burn? **Yes No**

Do you go to the tanning salon? **Yes No**

Do you form thick raised scars from cuts or burns? **Yes No**

Have you ever had a chemical peel or enzyme peel? **Yes No**

Do you have hyperpigmentation/hypopigmentation after a physical injury? **Yes No**

Have you ever had a laser procedure? **Yes No**

If yes, what area? _____

How long ago? _____

Female Patients Only:

Are you pregnant? **Yes No** Brown Patches? **Yes No**

Breast Feeding/Nursing? **Yes No** Birth Control? **Yes No**

Menopausal? **Yes No** Last Menstrual Cycle? _____

Irregular Periods? **Yes No**

Please answer the following questions:

Experience easy bruising/bleeding or excessive bleeding requiring special treatment? **Yes No**

Have you ever had Bioalcamide (permanent filler) injected anywhere in your face? **Yes No**

Do you or any family members suffer from the following neurological disorders:

Myasthenia Gravia**Yes No**

Eaton Lambert Syndrome **Yes No**

Do you smoke? _____ Amount/Week? _____

Do you drink? _____ Amount/Week? _____

Date/Type last drink: _____

Circle any of the following which you presently have or have had:

HIV/AIDS	Herpes/Cold Sore	Broken Capillaries
Skin Sensitivities	Rosacea	Acne
Cancer	Migraines/Headaches	Anemia
Diabetes	Seizures/ Epilepsy	Jaundice
Heart Trouble	Stroke	Arthritis
Angina	Lupus	Warts
Emphysema	High Blood Pressure	Pace Maker
Tuberculosis	Heart Murmur	Hepatitis
Asthma	Rheumatic Fever	Liver Disease
Thyroid Disease	Mitral Valve Prolapse	Stomach Ulcer
Hirsutism	Kidney Disease	Fainting Spells
Sinus Trouble	Glaucoma	Skin Conditions
Metal Implants	Keloids	Blood Disorders
(Including IUD)	(Excessive Scarring)	(bleeding/clot)
Blood Transfusion	Aspirin/Blood Thinner	Sickle Cell
Addictions	Artificial Valve	Artificial Joint
Alcoholism	Prosthesis	Oral Corticosteroids Cardiac Pacemaker
Dental Procedures	Psych Treatment	Eczema

Do you have or have had any other health problems not listed on this form? **Yes No**

If yes, please explain: _____

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any changes in my health, or my medications change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

_____ _____

Signature Date

General Photography Release

I hereby authorize BodyRx/Riverside Medical, hereafter referred to as "Company," to publish photographs taken of me, for use in the BodyRx's print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless BodyRx from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release BodyRx, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed Name: _____ Date: _____

Signature: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Refund Policy

BodyRx offers NO refunds or exchanges on any products or services.

Financial Policy

All services require payment prior to services being rendered. Insure you have correctly answered the prescreen questions if you are a weight loss client to avoid paying for a service you do not qualify for.

NO CHECKS, NO HEALTH SAVINGS ACCOUNT, NO FLEXIBLE SPENDING ACCOUNTS

Tardiness

Appointment times for massage are as scheduled and cannot extend beyond the stated tie to accommodate late arrivals. Please be on time for your appointment.

If arrival is delayed for spa services, we will make every effort to accommodate your appointment, but this is not always possible. Service time may be abbreviated to avoid delays for other guests as treatments are charged at the full value. Appointments missed by 15 minutes or more are cancelled with a 100% spa credit for the treatment amount missed, which is yours to use once your treatment is rescheduled.

Sickness

Massage/Bodywork is not appropriate care for infectious or contagious illness. Please cancel or reschedule your appointment as soon as you are aware of an illness.

Children

Children are expected to be on their best behavior, and be supervised by an adult guardian at all times. We do not have facilities to care for children and hope you understand we cannot assure their safety in a professional environment. We also do not want to compromise the experience of our other guests. If your child is unable to accompany you during your service, you will be asked to reschedule your appointment.

Cancellation Policy

BodyRx Louisville enforces a 24-hour cancellation policy for ALL appointments. In order to reschedule your appointment, you must notify BodyRx at (502)882-8680/ (502) 974-3447 24 hours before your scheduled appointment time to avoid being charged a **$50 cancellation/no show fee**. If you fail to show up to the scheduled appointment or cancel within 24 hours, we are hereby authorized to initiate entries to the debit/credit card account that is on file. If you do not have a card saved on file, please understand that you will receive a bill and that the fee must be paid prior to scheduling another appointment.

_____ _____

Signature Date

Do you know what we have to offer at our medical spa?

Please circle anything that interests you; we would love to tell you more about it!

Body TreatmentsSkin Care ProductFacial Treatments

Massage	ZO Skin Care	Lash & Brow Tinting
Back Treatment	Glo Minerals	Chemical Peels
Body Sculpting		Customized Facials
		Laser Facial
		Microblading
		HydraFacial
		Dermaplaning

InjectablesVein TreatmentsHair Removal

Botox	Laser Vein Removal	Waxing
Dermal Fillers	Sclerotherapy	Threading
PDO Threading		Laser Hair Removal

Hair GrowthWeight Management

Viviscal Shampoo	Medical Weight Loss Program
Viviscal Conditioner	Ultra-Burn Injections
Viviscal Elixir	
Viviscal Supplements	

Do you have any skin concerns? **Yes** or **No**
How would you like for us to contact you? **Text**____ **Call**____ **Email**____
Free Consultation? **Yes** or **No**

bodyrxlouisville.com

Client Name: _____
Date: _____
Client Signature: _____