Natura Wellness Clinic

Chiropractic • Naturopathy • Massage Therapy • Acupuncture

211-3885 Duke of York Blvd., Mississauga ON L5B 0E4 T:(905)276-6800 F:(905)276-6802

MEDICAL AESTHETICS - FOR OFFICE USE:

Full Name:	Today's Date:

Phone Number:	Email:

Date of Birth:	Gender:	Pronoun:

Address:

Spa Wrap Size Preference:

☐ S|M ☐ L | XL ☐ 2XL | 3XL ☐ None

Scent Preference / Aversions:

Use of Topical Prescriptions / Allergies:

Questions:

Skin Type:

Skin Concerns:

Most Recent Facial / Treatment / Procedure:

Prior reactions to skincare, cosmetics, treatments, etc.:

Where do you shop for your skincare products? :

How much time do you spend on your daily skincare routine? :

What are your goals with your skin? :

Do you tan, smoke or drink? If so, how often? :

How often do you exercise? What exercise interests you? :

How much do you sleep on average? :

How often would you like to come in for treatments? :

Medical History – Please check ALL that apply

☐ Accutane	☐ Acne	Allergies: _____
☐ Arthritis	☐ Depression	☐ Metals in Body
☐ Epilepsy	☐ Diabetic	☐ Heart Condition / Pacemaker
☐ Fever Blisters	☐ Eczema	☐ Blood Pressure
☐ HIV	☐ Hepatitis	☐ Pigmentation
☐ Lupus	☐ Insomnia	☐ Thyroid
☐ Plastic Surgery	☐ Pregnant	Medications: _____
☐ Psoriasis	☐ Seborrhea	☐ Planning on Pregnancy
☐ Vitamins	☐ Shingles	☐ Skin Cancer
☐ Rashes	Other: _____	Surgeries: _____
☐ Warts		

Personal Skin Care History – Please check ALL that apply

☐ Make-Up Remover	☐ Eye Cream	☐ Neck Cream	☐ Cold Roller
☐ Facial Cleanser	☐ Lip Treatment	☐ Body Wash	☐ Gua Sha
☐ Toner	☐ Mask	☐ Body Scrub	☐ Reflexology
☐ Serum	☐ Retinol	☐ Body Mask	☐ Facial/Body Massage

Add-ons & Consent

Full Name:

1. **Have you ever used Retinol in the last 15 days?** ☐ Yes ☐ No

   If yes, when was your last application?

2. **Have you had any treatments, peels, laser or injectables in the last 30 days?** ☐ Yes ☐ No

   If yes, please provide details below:

3. **Are you interested in any add-ons during your appointment today?** ☐ Yes ☐ No

   If yes, which add-ons interest you most?

Questions / Anything you want us to know:

This form is designed so we can get to know you better!

Consent: I understand and voluntarily accept the risks associated with all services. I agree that this wavier is in effect for all services, and will not expire unless specifically requested by either party. By signing this form, I agree to the above terms, authorizing the clinic to retain my personal information on my private client account, and release the clinic and its employees from any liability or claims.

We will not treat clients with: questionable medical conditions, open wounds or sores, infections, recent dental work, healing incisions, etc.

I understand that the treatments I receive are not a substitution for medical treatment.

Please provide 24 hours notice of cancellation for your appointment. A fee of $40 will be charged to your account if you do not show up for your appointment or if you choose to cancel within 24 hours of your appointment time.

Late arrivals will be seen for the remainder of their appointment time only. It is our goal to stay on schedule to the best of our abilities to serve all patients in a fair manner.

Signature & Date

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