Germantown Day Spa Salon & Medical Aesthetics
Needs Assessment

Date:_____

First Name:_____Last Name:_____DOB___/____/____Age:_____

Phone:_____

Address:_____City_____State:_____Zip:____

Email:_____

Are you currently under the care of a physician or dermatologist? If yes, what reason?_____

Current Medications (Prescription or over the counter including vitamins and supplements):

Have you ever had an allergic reaction to any medications or over the counter products?
___Yes ____No

Please list the name of the medication or product: _____

Any Allergies to food, environment or medications: _____

History:	**Yes**	**No**	**N/A**	**Date**
Recent Sun Exposure	X	X	X	_____
Other Weight Loss Treatments	X	X	X	_____
Gold Therapy	X	X	X	_____
Herpes/Cold Sores	X	X	X	_____
Vitiligo (loss of skin Pigmentation)	X	X	X	_____
History Melanoma	X	X	X	_____
Keloids/Hypertrophic Scarring	X	X	X	_____
Scarring in treatment Area(s)	X	X	X	_____
Tattoos/Permanent Make-up	X	X	X	_____
Fillers, Botox, etc.	X	X	X	_____
Pacemaker/Defibrillator	X	X	X	_____

Implants/Surgeries in treatment area	X	X	X	_____
Decreased sensation/Numbness in treatment area	X	X	X	_____

Do you have or have you ever had any of the following medical conditions?
(*Check all that apply)*

_____Cancer
_____Diabetes
_____Epilepsy
_____Heart Problems
_____Claustrophobia
_____High Blood Pressure
_____Hepatitis
_____Irregular Sleep Patterns

_____ Hormone Imbalance
_____ Hysterectomy
_____ Thyroid
_____ Varicose
_____ Cold Sores/Fever Blisters
_____ Keloid Scarring
_____ Blood Clotting Abnormalities
_____ Any Active Infection

For Liposonix Candidates Only

Weight Goal:_____

What areas would you like for us to assess for you regarding fat reduction?

_____

What have you done in the past to reduce weight, tighten or tone these areas?_____

_____

_____

As with most aesthetics treatment, some patients may experience mild discomfort during the Liposonix treatment. During the treatment you may feel cold, prickling, tingling, warmth, mild, discomfort, or pain. After the treatment, you may have a temporary redness, mild to moderate bruising, discomfort and/or swelling in the treated area(s). To increase comfort, our medical staff will asses and determine what pain management is necessary for you.

Are there other areas of your body you would like one of our professional staff to discuss with you? Please Circle all that apply.

FACE	**WRINKLES**	**SKIN TIGHTENING**	**ANTI-AGING**
VARICOSE VEINS	**SKIN CARE**	**BOTOX**	**WAXING**
FACIAL/SKIN PEELS	**LASER HAIR REMOVAL**	**BROWN SPOTS/ UNEVEN SKIN TONE**	**ACNE**
THERAPEUTIC MASSAGE	**NAIL CARE/ MAINTENANCE**	**HAIR CARE**	**OTHER:**

Have you taken pain medication or anti-anxiety medication before? (*circle) YES NO
If so, what pain medications and/or anti-anxiety medications have you taken_____

_____

Do you drink alcohol? YES or NO **Do you smoke? YES or NO**

___Daily ____Weekly ____Socially ____Daily _____Weekly _____Socially
Do you have any other health problems or medical conditions that our office should be aware of? If so, please list:_____
Are you currently using any topical medications or creams? If so, please list:_____

_____

Patient Pharmacy and Location_____

Pharmacy Phone Number_____

For our Female Patients: (circle)

	Yes	**No**
Are you pregnant?	X	X
Are you breastfeeding?	X	X
Trying to become pregnant?	X	X
Do you have regular 28 day cycle periods?	X	X
Do you have heavy and or painful periods?	X	X
Are you going through or have you gone through menopause?	X	X

I certify that the preceding medical, personal and skin history statement are true and correct. I am aware that it is my responsibility to inform Germantown Day Spa, Salon and Medical Aesthetics of my current medical history as it is essential for the caregiver to execute appropriate treatment procedures.

I UNDERSTAND WHAT I HAVE READ AND TAKE RESPONSIBILITY FOR MY PART IN THE POST TREATMENT TIME FRAME FOR MY BEST RESULTS.

Patient Signature:_____Date:_____

Notes: _____

Clinician Signature:_____Date:_____