THE SPA AT DAYTONA COLLEGE
Skincare

Student Name: _____ Clinic Number: _____

PERSONAL DATA			
Name		**Date**	
Address		**Phone (day)**	
City/State/Zip		**Phone (eve)**	
Birth Date		**Occupation**	
Emergency Contact		**Current Dermatologist**	

YES	NO	Please Answer The Following Questions
		Is this your first skincare procedure? **If no, what was the date of the last treatment?**
		Have you ever been here before? **If yes, what was the last treatment & when was it?**
		Are you currently seeing a medical practitioner? **If yes, for what reason or condition(s)?**
		Are you pregnant? **If yes, how many months?**
		Are you currently taking any medications? **If yes, which ones?**
		Do you smoke?

What are the reason(s) for your visit today? **What special areas of concern do you have?**

Please Check The Conditions You've Experienced/ Star (*) If Have Occurred In The Last 2 Years					
	Accident		**Eating Disorder**		**Immune Disorders**
	Acne		**Eczema**		**Low Blood Pressure**
	Allergies		**Epilepsy**		**Lupus**
	Anxiety		**Fever Blisters**		**Metal Pins, Screws, or Plates**
	Arthritis		**Headaches – chronic**		**Pacemaker**
	Asthma		**Head Injuries**		**Rashes**
	Blood Clots		**Heart Condition**		**Sinus Problems**
	Cancer/Tumors		**Hepatitis**		**Stroke**
	Claustrophobia		**Herpes**		**Surgeries**
	Depression		**High Blood Pressure**		**TMJ/Jaw Pain**
	Digestive System Issues		**Hysterectomy**		**OTHER:**
	Diabetes		**Infections**		**OTHER:**

Have you had skin cancer? If yes, when?

Have you ever had chemotherapy or radiation? If yes, when?

Check if you are now using or have ever used:

Azalex_____ Differin_____ Renova_____ Retin-A_____ Accutane_____

Birth Control Medication_____ Hormone Replacement_____ Contact Lenses_____

I understand that _________________________________ is a student at Daytona College & that I am assisting him/her in a Lab Skincare Session for the sole purpose of completing required clinical theory and practice. I understand that there are students of varying degrees of competency enrolled in the program: some are seniors, preparing to graduate, and others are recently enrolled in the program. All are skilled and competent with the techniques employed today at the clinic. Should you need specific skincare services performed, we can refer you to any of our licensed graduates or other health care providers.

I hereby agree & acknowledge that this lab session shall not be considered a professional service & that the student shall not be considered a licensed professional.

I also hereby agree that I have stated all known past & present medical conditions. If any condition is deemed dangerous in nature, I agree to take the responsibility to consult a healthcare practitioner for further diagnosis and/or treatment. Therefore, I shall keep the student informed of any updates to my health condition(s) & shall not hold the student or Daytona College liable for any health changes which may occur.

Signature:____ Date:__________________

Please remove all jewelry & turn cell phones off.

CLIENT'S IMPRESSIONS & COMMENTS

YES	NO	PLEASE PLACE AN X IN THE APPROPRIATE BOX
		Were you greeted pleasantly?
		Were you told what to do and explained what was going to take place?
		Were you satisfied with your session?
		Was there anything that made you uncomfortable?
		Did you feel your therapist listened to you?
		Did you feel that your therapist was properly skilled and confident?
		Would you receive another professional service from this therapist?

Circle how well you feel the student addressed your specific needs? Poor Fair Good Excellent

General Comments:____

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Signature:____ Date:__________________

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INFORMATION BELOW TO BE FILLED OUT BY THE STUDENT/THERAPIST ONLY

Student's Comments:____

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