Neroli
Institute

☐ 6051 Arlington Blvd, Suite B,
Falls Church, VA 22044
703.241.2173

☐ 1880 Howard Ave, Suite 203
Vienna, VA 22182
703-356-6143

HEALTH HISTORY INFORMATION

NAME **Today's Date:**

LAST: **FIRST:** **M.I:**

HOME ADDRESS:

DATEOF BIRTH: **AGE:** **Sex:** **Female** ☐ **Male** ☐

HOME PHONE: **CELL PHONE:**

EMAIL:

I consent to this email address to be added to the Med Spa and will be used to send email and newsletter, where I will get information on specials and promotions. Yes ☐ **No** ☐

LEAVE MESSAGES AT: **Home** ☐ **Cell** ☐ **Email** ☐

OCCUPATION:

PRIMARY CARE PHYSICIAN|PHONE NUMBER:
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? [name and phone]

UNLESS OTHERWISE INDICATED, WE HAVEPERMISSION TOCOMMUNICATE CHANGES IN YOUR HEALTH STATUS, INCLUDING SURGERY, TO OTHER PHYSICIANS PARTICIPATINGIN YOURCARE.
Yes, May Notify ☐ **No, Please Do Not Notify** ☐

DOYOU HAVE ANY MAJORMEDICAL PROBLEMS, SERIOUS ILLNESS? Yes ☐ **No** ☐
IF SO, PLEASE LIST:
PLEASE LIST ALL PRIOR SURGICAL PROCEDURES ANDDATESPERFORMED:

PLEASE LIST ALL INJECTABLE PROCEDURES {Botox, Jevederm, Restylane, Collagen, etc.} AND DATES PERFORMED.

MEDICAL HISTORY

DO YOU HAVE APACEMAKER OR DEFIBRILLATOR?..... ☐

DO YOU SUFFER FROM "PHOTOSENSITIVITY" {EXTREME SENSITIVITY TOSUNLIGHT} ..... ☐

DO YOU HAVE A HISTORY OF EASY/EXCESSIVE HYPERPIGMENTATION?..... ☐

DO YOU FORM KELOID SCARS?..... ☐

DO YOU HAVE ANY METAL IMPLANTS?..... ☐

DO YOU WEAR CONTACT LENSESES?..... ☐

HAVE YOU TAKEN ACCUTANE, RETIN A, OR RENOVA IN THE PAST 12MONTHS?..... ☐

ARE YOU CURRENTLY TAKINGCOUMADIN [Warfarin]OR OTHER BLOOD THINNERS?..... ☐

DO YOU REQUIRE ANTIBIOTICS BEFORE PROCEDURES SUCH AS DENTAL CLEANINGS?..... ☐

DO YOU SMOKE? Yes ☐ No ☐ IF YES, HOW MANY PACKSPER DAY?

DO YOU DRINK ALCOHOL? Yes ☐ No ☐ IF YES, QUANTITY PER WEEK?

HAVE YOU EVER HAD AN ADVERSE REACTIONTO LASER OR COSMETIC TREATMENTS?
Yes ☐ No ☐ IF SO, PLEASE LIST:

ARE YOU ALLERGIC TO ANY MEDICATIONS?..... ☐
IF SO, PLEASE LIST:

DO YOU HAVE ANY OTHER ALLERGIES?..... ☐
IF SO, PLEASE LIST:

DO YOU TAKE ANY OF THE FOLLOWING **[Please check]:**

- ☐ **all that apply and/or list additional medications**
- ☐ **ANTI-COAGULANTS**
- ☐ **ANTI-DEPRESSANTS**
- ☐ **APPETITE DEPRESSANTS**
- ☐ **ASPIRIN OR IBUPROFEN**
- ☐ **BLOOD PRESSURE MEDICATION**
- ☐ **CORTISONE OR STEROIDS**
- ☐ **ANTIBIOTICS**
- ☐ **HORMONES/CONTRACEPTIVES**
- ☐ **NSULIN**
- ☐ **NSAIDS**
- ☐ **SEDATIVES**
- ☐ **THYROID MEDICATION**
- ☐ **OTHER**

ARE YOU TAKING HERBAL PREPARATIONS OR VITAMINS [St. JohnsWort, Vitamin E, etc.]? **Yes** ☐ **No** ☐
ARE YOU OR MIGHT YOU BE PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU TRYING TO BECOME PREGNANT?..... **Yes** ☐ **No** ☐
ARE YOU NURSING?..... **Yes** ☐ **No** ☐

HAVE YOU EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING ANESTHETICS? IF SO, PLEASE SPECIFY:

- ☐ **BLOCK [e.g., dental]: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **LOCAL: Ineffective |Heart palpitations |Systemic reaction| Other:**
- ☐ **TOPICAL: Ineffective |Heart palpitations |Systemic reaction| Other:**

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING [Please check all that apply]:

- ☐ **Active Infection**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Bleeding Disorders**
- ☐ **Blistering Sunburns**
- ☐ **Circulation Problems/Blood Clots**
- ☐ **Cold Sores/Shingles**
- ☐ **Collagen Disorders**
- ☐ **Diabetes (Type__)**
- ☐ **Easy Bruising**
- ☐ **Endocrine/Hormonal Issues**
- ☐ **Eye Problems**
- ☐ **Fatigue**
- ☐ **Fibromyalgia**
- ☐ **Headaches/Migraines**
- ☐ **Heart Condition**
- ☐ **Hepatitis**
- ☐ **High/Low Blood Pressure**
- ☐ **Other**
- ☐ **Hormonal Imbalance**
- ☐ **Insomnia/Sleeping Problems**
- ☐ **Joint Injury**
- ☐ **Multiple Sclerosis**
- ☐ **Muscle Pain/Spasms**
- ☐ **Neurological Disorders**
- ☐ **Permanent Makeup/Tattoo**
- ☐ **Pigmentation Disorders**
- ☐ **Psoriasis**
- ☐ **Melanoma**
- ☐ **Scleroderma**
- ☐ **Skin Cancer**
- ☐ **Skin Injury**
- ☐ **Stroke**
- ☐ **Unusual Moles**
- ☐ **Varicose Veins**
- ☐ **Vision Deficits**
- ☐ **HIV/AIDS**

SKIN CARE HISTORY AND CONCERNS

PLEASE LIST ANY PRODUCTSTHATIRRITATEYOUR SKIN:

HAVE YOU HAD UNPROTECTED SUN EXPOSURE OR BEEN IN A TANNINGBOOTH IN THE LAST 2 WEEKS? Yes ☐ No ☐

DOYOU USE SELF TANNERS? Yes ☐ No ☐ IF YES, WHEN WAS THE LAST APPLICATION?
ARE YOU PLANNING A VACATIONIN THE SUN IN THE NEXT 3-6MONTHS? Yes ☐ No ☐

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST6WEEKS?
SHAVING ☐ WAXING ☐ ELECTROLYSIS ☐ PLUCKING/TWEEZING ☐ STRINGING ☐
EPILATORIES ☐
PLEASE INDICATEYOUR CURRENT SKIN CARE PRODUCTS/REGIMEN:

THERAPIST/PROVIDERREVIEWED: SIGNATURE _____ DATE_____
THERAPIST PRINTED NAME:

EXCLUSIONARY CRITERIA FORM

Yes ☐ No ☐	**I have had unprotected sun exposure, used a tanning Bedor applied a tanning cream inthe area(s) to be treated within the six weeks prior to my first treatment on a regular basis (tanned skin will not be treated with laser). Protected sun exposure means wearingprotective clothing or the daily use of an SPF-30 or greater sunscreen.**
Yes ☐ No ☐	**I have used a mechanical form of epilation with the six weeks prior to my first treatment (this applies to laser hair removal treatments only.) Mechanical epilation includes Plucking, waxing, tweezing, electrolysis, threading, or sugaring.**
Yes ☐ No ☐	**I have a history of seizures. Flashing lights may trigger a seizure.**
Yes ☐ No ☐	**Medications I am taking Accutane, anticoagulants or St.John's Wort. I am taking a medication or herbal remedy that may make my skin sensitive to light (photosensitizing).**
Yes ☐ No ☐	**I have a history of keloid and hypertrophic scar formation. Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason, it is recommended to exclude from treatment clients with known tendency to form keloid or hypertrophic scars. Clients with this history are evaluated on a case-by-case basis to determine if treatment can be performed.**
Yes ☐ No ☐	**I have an active infection or am immune suppressed. (Active infections and immuno- suppression compromise the healing ability of the body).**
Yes ☐ No ☐	**I have an open lesion in the area to be treated.**
Yes ☐ No ☐	**I have a history of Herpes I or II within the area to be treated.**
Yes ☐ No ☐	**I am using or have used within the two weeks prior to treatment Tretinoin (Retin-A, Renova) or a retinol product in the area to be treated.**

PLEASENOTE A “YES” TO ANY OF THE ABOVE MAYEXCLUDE CLIENT FROMTHE LIGHT THERAPY (LASER/IPL) TREATMENTS.

PRINT CLIENT NAME:

SIGNATURE: DATE:

WITNESS: DATE:

MY SPECIFICCONCERNS AND INTERESTS

Please check all that apply and indicate any prior treatments in space provided)

CONCERNS	LIST ANY PRIOR TREATMENT AND APPROXIMATE DATE(S): [Accutane/Botox/Peels/IPL/Lasers/Surgery/etc.]
◯ Skin discoloration	
◯ Brown Spots	
◯ Acne	I have used Accutane: Yes ◯ No ◯ Last Dose:
◯ Rosacea	
◯ Fine Wrinkles	
◯ Lip Lines	
◯ Thin Lips	
◯ Nasolabial Creases	
◯ Marionette Lines	
◯ Loose Skin	
◯ Aging Hands	
◯ Excessive Sweating	
◯ Facial/Body Hair	
◯ Scars	
◯ Facial Veins	
◯ Leg Veins	
◯ Not Certain	
◯ Toenail Fungus	
◯ CoolSculpting Body Contouring	
◯ Other	

CLIENT SIGNATURE: **DATE:**

PRINTEDNAME:

PROVIDER NAME ANDSIGNATURE: **DATE:**

Refund , Return and Cancellation Policy

As a courtesy to other Spa guests and our therapists, please give at least a 48-hour notice of cancellation to avoid a $25 charge or as a penalty one of your sessions taken away. A credit-card number , advanced payment, or gift-certification number may be required at the time of booking. For spa packages and two or more guests coming together we require a 48 - hour cancellation notice. Groups and bridal parties will require a 50% deposit at the time of booking. A refund is not available after you have used a portion of the services you booked.After one session the fee for package of two is non-refundable.Please ask new update of our staff about our refund and return and cancellation policy.Educational programs After two sessions the fee for programs is non-refundable.We do not provide refunds for cancelled or missed appointments.

CLIENT SIGNATURE: **DATE:**