Tiszta Viz Organic Skin Care & Spa

New Client Consultation Form

Name _____

Occupation _____ Birthdate _____

How did you hear about us? _____

****

Emergency Contact _____ Phone # _____

Are you pregnant? Yes ◯ No ◯ Do you Smoke? Yes ◯ No ◯

Medical History (*Please check all that apply*)

☐ Bone Problems	☐ Urinary Problems	☐ Contact Lenses
☐ Muscular Problems	☐ High Blood Pressure	☐ Varicose Veins
☐ Digestive Disorders	☐ Low Blood Pressure	☐ Diabetes
☐ Circulatory Disorders	☐ Skin Disorders	☐ Heart Problems
☐ Glandular Disorders	☐ Retina A/Accutane	☐ Metallic Implants

Notes to Medical History

Please list current medications

Please list all known allergies

I understand it is my responsibility to inform Tiszta Viz Organic Skin Care & Spa of any changes to the information I have provided above. This information will be kept confidential. We require your signature to keep your personal treatment and sales information on file. Thank you!

Please type your name in the signature box below and enter the date.
This will be commensurate with your signature.

Client Signature _____ Date _____