

Tiszta Viz Organic Skin Care & Spa

New Client Consultation Form

Name: _____ Date: _____

Occupation: _____ Birthdate (mm/dd/yyyy) _____

How did you hear about us? _____

Emergency Contact: _____ Phone #: _____

Medical History *(Please check all that apply)*

Are you pregnant: Y/N _____ Do you Smoke? Y/N _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Bone Problems | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Contact Lenses |
| <input type="checkbox"/> Muscular Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Circulatory Disorders | <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Glandular Disorders | <input type="checkbox"/> Retina A/Accutane | <input type="checkbox"/> 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!

Customer Signature: _____ Date: _____