Tiszta Viz Organic Skin Care & Spa

New Client Contact Information

First Name: _____ Last Name: _____

Street Address: _____

City/Town: _____Postal Code: _____

Date of Birth: _____ Email: _____

Primary (best) phone#: _____ 2nd phone#: _____

May we contact you with upcoming promos/events? Yes • No •

How do you prefer to be contacted? • Phone • Email

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_____

O Bone Problems	O Urinary Problems	O Contact Lenses
O Muscular Problems	O High Blood Pressure	O Varicose Veins
O Digestive Disorders	O Low Blood Pressure	O Diabetes
O Circulatory Disorders	O Skin Disorders	O Heart Problems
O Glandular Disorders	O Retina A/Accutane	O 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: _____