The Spine and Wellness
Facial Intake Form

First Name: _____Last Name: _____DOB:_____

Address: _____City:_____St:_____Zip:_____

Home #:_____Cell#:_____

Work#:_____Email:_____

Emergency Contact: _____Phone#:_____

Whom May we thank for referring you: _____

Physician: _____

Exposure to the sun (please circle): never / light / moderate / excessive
What is your sunscreen regimen? _____
How do you prefer to get skin color? __Sunbathe __Self-Tanning __Tanning Bed __ Nothing
How would you describe your skin? ___Normal to oily ____Normal to Dry ____Extremely Oily ____Extremely Dry ____Acne ____Combination
Do you experience? ____Flakiness ____Tightness ____Redness ____Excessive oily shine during the day
What type of foundation do you wear? ____liquid ____Powder ____Cream ____None
How does your skin heal? __Fast __Pigments __Scars __heals poorly
Do you bruise easily? Yes / no
Any personal or family history of cancer? Yes / no
Do you take care of your skin at home? Yes / no
Please describe: _____
Is this your first skin care treatment? Yes / no If no, what have you liked about previous treatments? _____
Do you smoke? yes / no If yes, specify daily amount:
Do you have (circle all that apply): epilepsy heart condition pacemaker skin cancer diabetes metal pins/plates skin diseases recent operations allergy to aspirin
Have you used Accutane in the past 12 months? yes / no
Have you used Retin-A in the past month? yes / no
Have you used any other oral/topical skin medications in the past 6 months? yes / no
If yes, please describe:_____
Do you have: allergies to latex? yes / no allergies to skin care products? yes / no Please list:_____
Are you currently on any medications? yes / no Please list:_____
_____
Have you ever suffered from claustrophobia? yes / no
Women only Are you (circle all that apply) pregnant, trying to become pregnant, not pregnant Taking Oral Contraceptives, Taking Hormone Replacements
Men only Do you suffer from Ingrown facial hairs yes / no Experience Razor Burn yes / no

Please circle if you are affected by or have any of the following:

Asthma, Fever blisters, Hysterectomy, Sinus Problems, Cardiac Problems, Headaches-chronic, Skin Disease, Immune Disorders, Depression, Anxiety, Hepatitis, Lupus, Eczema, Herpes, Epilepsy, High Blood Pressure, Pace Maker, Metal bone, pins or plates

Please explain above problems or list any other significant issues.

_____

How would you describe your overall health?

___ Excellent ____Good ____Fair ____ Poor

Have you ever had a reaction to?

___Cosmetics ___Metals ____Medication ____ Food ____Fragrance ___Other _____

My treatment goals for each area are:

1._____

2._____

3._____

Is there anything else that we should be aware of before we start working together on improving your skin? _____

My top 3 areas of concern are:

_____

_____

This form is completely confidential. Completion of this form gives a general state of health and assists our specialist in directing a customized course of treatment for you.

The information I have provided about my medical history is accurate to the best of my knowledge. ***I agree to accept responsibility for omissions regarding my failure to disclose any existing or past health condition.***

_____

Patient Signature Date

_____

Technician Signature Date

The Spine and Wellness Center
Medical Appointment Cancellation Policy

Dear Patient/Client:

We strive to render excellent care to you and the rest of our patients and clients. Your care and treatment is a priority to us. We also ask that you respect your therapist's time and expertise as well.

In an attempt to be consistent with this, we have a Medical Appointment Cancellation Policy that allows us to schedule appointments for our patients, with respect for your time, the next patient's time, and the doctor and therapists time.

Our policy is as follows:

We request that you give **24 hours' notice** in the event that you cannot make it to your scheduled appointment. If a patient misses an appointment without contacting our office, it is considered a missed or "No Show" appointment. A fee as shown below will be charged to your credit card, depending on the type of appointment missed. Additionally, if a patient is more than 15 minutes late for an appointment, it will be considered a "no show" appointment, and that appointment will be rescheduled. Also, if you miss more than **3** appointments, Dr. Borja reserves the right to discharge you from the practice for failing to follow treatment recommendations.

If you have any questions regarding this policy, please let our staff know, and we will be happy to clarify the policy for you.

We look forward to being a part of your continued wellness.

I have read and understand the Medical Appointment Cancellation Policy of The Spine and Wellness Center, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to these terms.

I, _____, have received a copy of The Spine and Wellness Center Medical Appointment Cancellation Policy.

_____ _____
Signature of Patient Witness

_____
Date

_____ _____ _____ _____
Credit Card Number Exp. CVV

__ Chiropractic $48.00 __ Massage $45.00 __ Physical Therapy $75.00
__ Skin Care $60.00 __ Laser Treatment $75.00 __ Special Service $100.00
__ Acupuncture $50.00 ____ Personal Training $45.00