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CONSULTATION FORM

At Silver Ridge Spa, we are committed to guest satisfaction. Please fill in the following information to the best of your knowledge. This will allow our staff to professionally customize your treatment and recommend the treatments and products that is ideally suited for your skin and personal concerns.

PERSONAL INFORMATION

NAME:	HOME PHONE:
ADDRESS:	WORK PHONE:
	CELL PHONE:
POSTAL:	EMAIL:
PROVINCE:	Preferred Contact (circle) HM WK Cell Email
	DATE of BIRTH Day/Month/Year ___/___/___

MEDICAL HISTORY

___ Bleeding Disorders/Bruising	___ Accutane within 6 months
___ Dermatologic Condition	___ Infection / Broken Bones
___ Photo Sensitive	___ History of Cold Sores
___ History of Keloid Scarring	___ Pregnancy
___ Pacemaker / Metal Implants	___ History of Skin Cancer
___ Diabetic	___ HIV / Hepatitis
___ Thyroid Condition	___ Recent Surgery / Botox / Filler
___ Clausterphobic	

LIST MEDICATIONS CURRENTLY: _____

OTHER MEDICAL CONDITION: _____

LIST ALLERGIES: _____

DATE: _____ SIGNATURE: _____

All information obtained is kept strictly confidential according to the Privacy Act.



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GUEST HISTORY FORM

DATE	SERVICE and PRODUCTS USED & COMMENTS	Esthetician