

Rebecca Siegfried, LMT #5606  
Micro current Non-surgical  
Facial and Body Sculpting

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Confidential Client Questionnaire & Medical History

Date: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

How did you hear about us?

\_\_\_\_\_

How often do you have a professional facial?

\_\_\_\_\_

Do you have sensitive skin? (Please describe):

\_\_\_\_\_

Do you have sensitive skin? (Please describe):

\_\_\_\_\_

Have you ever had any of the following cosmetic procedures? When?

\_\_\_ Chemical Peel When: \_\_\_\_\_

\_\_\_ Microdermabrasion When: \_\_\_\_\_

\_\_\_ Skin Resurfacing When: \_\_\_\_\_

\_\_\_ Botox When: \_\_\_\_\_

\_\_\_ Injectable Filler When: \_\_\_\_\_

\_\_\_ IPL When: \_\_\_\_\_

\_\_\_ Surgery When: \_\_\_\_\_

Lifestyle choices can significantly improve or slow the results of this procedure. The following information will enable us to best customize your program.

Smoking (type and amount per day): \_\_\_\_\_

Alcohol Intake (type and amount per week): \_\_\_\_\_

Salt Intake (type: sea salt, regular table salt): \_\_\_\_\_

Caffeine Intake (type and amount per day): \_\_\_\_\_

How many hours of sleep do you get per night? \_\_\_\_\_

How many ounces of water do you drink per day? \_\_\_\_\_

Have you lost or gained significant weight in the last 12 months? If so, how much?

\_\_\_\_\_

Do you exercise? \_\_\_\_\_

Certain conditions may restrict or preclude this treatment. Please indicate if you have ever had any of the following, and if so, for how long or date when treated:

<b>Condition</b>	<b>For How Long</b>	<b>Date(s) Treated</b>	<b>Please Provide Details</b>
Do you wear contacts?			
Epilepsy			
Pacemaker/ Pacemaker Leads			
Currently Pregnant			
Heart Condition			
Muscular Condition			
Metal IUD (tummy toning only)			
Cancer			
Skin Disorders			
Inflammation, infection, disease of skin			
Recent scar tissue			
Facial metal implants			
Lack of normal skin sensation			
Skin allergies			
Circulatory problems			
Previous cosmetic procedures or surgery			

\*If you checked yes to any of the conditions listed above, additional space is provided here for you to describe those conditions in further detail:

\_\_\_\_\_

\_\_\_\_\_

## Consent and Authorization

**TRUTH IN ADVERTISING:** I understand that this procedure is not a replacement for surgical or medical needs and that there are no guarantees, implied or otherwise, as to the results or benefit that I may obtain from the professional who is performing this procedure on me. I also understand that optimal results may not be obtained even if my program is followed correctly.

**INFORMED CONSENT:** I hereby authorize Rebecca Siegfried, LMT# 5606 to administer and direct a skin rejuvenation process using the Non-surgical Microcurrent Facial or Body Sculpting and hereby relieve them and hold them harmless from all liability for injury or damage that may occur to me. I understand that this consent is being given in advance and is given voluntarily. I further understand that if I have any medical condition outlined above that I should first consult with my physician prior to beginning any skin care program. Rebecca Siegfried, LMT# 5606 shall not be liable for any injury or damages to any client, guest or property of any client, member or guest or be subject to any claim, demand, injury or damages, whatsoever, including without any limitations those damages resulting from act of active or passive negligence on the part of Rebecca Siegfried, LMT# 5606, its successors or assigns and any of its officers or agents.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

I authorize the use of my before/after photos for marketing and I understand I will receive a free gift if they are used: \_\_\_\_\_ (please initial)