THE OASIS

Expert Hair Color Center

Salon & Spa

Basic Client Information:

Name:________________________________

Telephone No. : (_____) _____ - _______

Primary Reason for your visit:

Health History: All answers are strickly confidential

Are you currently take any medications (____) No (____)Yes

If Yes please List (Include prescriptions, over the counter meds, vitamins and /or herbal supplements

____

____

Have you ever had or do you currently have any of the following (check all that apply):

Cancer ( ) Stroke ( ) High Blood Pressure ( ) Low Blood Pressure ( ) Arthritis ( )

Heart Problems ( ) Blood Clots or Phlebitis ( ) Liver Problems ( ) Bladder Problems ( )

Frequent Headaches ( ) Kidney Problems ( ) Chronic Back Pain ( ) Chronic Neck Pain ( )

Are you Currently Pregnant? ( ) No ( ) Yes ; If Yes, how far along are you (# of Weeks) _____

If Pregnant are you having any problems associated with your pregnancy? (Explain)

____

Have yousuffered any acute injury in the past year ( ) No ( ) Yes If Yes; Explain:

____

Do you have a fever today? ( ) No ( ) Yes Have you had one in the past week? ( )No ( ) Yes

Are you Diabetic? ( ) No ( ) Yes

Please explain any medical conditions or concerns we should be aware of:

My Signature indicates that I accept resonsibility for the honesty of my above answers and that I have completed the form to the best of my ability.

Signed:

Date: