STONE & SAGE
HAIR + SKIN STUDIO

New Client Consultation & Health History

Please complete before your first appointment. Everything you share is kept confidential and helps me design a service that is safe and effective for you.

CLIENT INFORMATION

FULL NAME | DATE OF BIRTH | TODAY'S DATE

PHONE (TEXT PREFERRED) | EMAIL

ADDRESS | CITY / ZIP

EMERGENCY CONTACT | EMERGENCY PHONE

HOW DID YOU HEAR ABOUT THE STUDIO? | OCCUPATION

YOUR GOALS

WHAT WOULD YOU LIKE TO FOCUS ON TODAY?

TOP THREE CONCERNS (HAIR, SCALP, OR SKIN)

SERVICES YOU ARE INTERESTED IN

GENERAL HEALTH HISTORY

QUESTION	YES	NO	DETAILS
Are you pregnant, breastfeeding, or trying to conceive?	☐	☐	
Do you have any allergies (products, latex, foods, medications, fragrance)?	☐	☐	
Any history of cold sores or fever blisters?	☐	☐	
Any autoimmune condition, diabetes, or thyroid disorder?	☐	☐	
Any heart condition, pacemaker, or metal implants?	☐	☐	
Any seizures, epilepsy, or neurological condition?	☐	☐	
Any cancer history, chemotherapy, or radiation?	☐	☐	
Any recent surgery, injectables, laser, or medical skin procedure?	☐	☐	
Do you smoke or use nicotine products?	☐	☐	

Please circle or check Yes / No. If yes, add detail on the lines provided.

MEDICATIONS & PRODUCTS

Please check anything you are currently using or have used in the last 12 months:

- ☐ Isotretinoin / Accutane (currently or within the last 12 months)
- ☐ Prescription retinoids — tretinoin, Retin-A, adapalene, tazarotene
- ☐ Oral or topical antibiotics (doxycycline, minocycline, tetracycline)
- ☐ Blood thinners — aspirin, warfarin, Eliquis, Plavix
- ☐ Steroids — prednisone, cortisone, topical hydrocortisone
- ☐ Hormonal medication, birth control, or fertility treatment
- ☐ Autoimmune, chemotherapy, radiation, or immunosuppressant therapy
- ☐ Diuretics, antihistamines, or acne medication of any kind
- ☐ Supplements, herbs, or essential oils used on the skin

LIST ALL CURRENT MEDICATIONS AND SUPPLEMENTS

CURRENT HAIR AND SKIN PRODUCTS YOU USE AT HOME

SUN, TANNING & AFTERCARE

QUESTION	YES	NO	DETAILS
Sun exposure, tanning bed, or spray tan within the last 14 days	☐	☐	
Planned sun exposure, beach/lake trip, or tanning within 14 days after treatment	☐	☐	
Current sunburn, windburn, or peeling skin	☐	☐	
Daily broad-spectrum SPF 30+ use	☐	☐	

Please circle or check Yes / No. If yes, add detail on the lines provided.

CONSENT TO SERVICE

I confirm the information above is accurate and complete to the best of my knowledge, and I will notify Sydnie Jones of any change in my health, medications, or product use before future services. I understand that services are cosmetic in nature, are not a substitute for medical care, and that results vary from person to person. I agree to follow all home-care and aftercare instructions provided to me.

ACKNOWLEDGEMENT & SIGNATURE

CLIENT NAME (PRINTED) SIGNATURE DATE

PARENT / GUARDIAN NAME (IF CLIENT IS UNDER 18) GUARDIAN SIGNATURE DATE

PROVIDER — SYDNIE JONES, LICENSED COSMETOLOGIST & ESTHETICIAN DATE