Karen Hawkins Skin Therapy

CONFIDENTIAL INFORMATION AND HISTORY

Referred by: _____

CLIENT FULL NAME: _____ DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS: _____

PHONE NUMBERS:

HOME: _____ WORK: _____ CELL: _____

OCCUPATION / EMPLOYER: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ SPOUSE NAME: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBERS:

HOME: _____ WORK: _____ CELL: _____

SPOUSE PHONE NUMBERS:

HOME: _____ WORK: _____ CELL: _____

PHYSICIAN: _____ PHONE: _____

DERMATOLOGIST: _____ PHONE: _____

ARE YOU ALLERGIC TO ANY FOODS OR MEDICATIONS? _____ IF YES, PLEASE LIST:

_____

_____

_____