Well of Life Center
FOR NATURAL HEALTH

Intake Form
for Oncology Esthetic Care

Oncology Facial Contraindications

May NOT be done if you have any of the following:

- Presence of infection: edema, pus
- Pain: sensitive to touch
- Open wounds: wounds that are not healing, susceptible to infection
- Rash: vesicles, inflammation, pruritus
- Moist desquamation: skin peeling with the presence of infection
- Chemo-induced acne: acne lesions produced by systemic chemotherapy
- Hyper sensitivity: extremely sensitive skin, contact dermatitis

These guidelines are in place for your protection and ours, as we strive to serve you to the best of our ability. Please contact our Client Advocate if you have any questions or need additional information.

Your answers to the questions on this form are essential for a safe, effective session. Please take some time to answer in detail, and have this paperwork completed prior to the start of your appointment.

Oncology Facial Intake Form

Client Information

First Name _____ MI _____ Last _____

Home Phone _____ Cell Phone _____

Street Address_____

City _____ State _____ Zip _____

Email Address _____

Have you had a facial therapy before? ____ Yes ____ No *If yes, when was your last facial?* _____

Have you ever had herpes (cold sores)? ____ Yes ____ No

If yes, have you ever been treated with Zovirax or any medication for herpes? ____ Yes ____ No

Do you wear contacts? ____ Yes ____ No

Are you on a diet? ____ Yes ____ No

Do you smoke? ____ Yes ____ No

Do you exercise? ____ Yes ____ No

Health Questionnaire

Are you currently under the care of a physician for cancer or any other health related issues?

____ Yes ____ No

When were you first diagnosed with cancer? _____

What type of cancer? _____

Where was/is it located? _____

Is this your first type of cancer? ____ Yes ____ No

If no, when was your last diagnosis? _____

Are you being treated now? ____ Yes ____ No *What was the date of your last treatment?* _____

What treatments have you undergone? *Please supply details, with dates and types of cancer treatments; attach another paper if necessary.*

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_____

_____

Current medications not described above: _____

_____

Please list any allergies: _____

Did your treatment include any removal or radiation of lymph nodes? ____ Yes ____ No

If yes, please describe where _____

Did your treatment include radiation therapy? ____ Yes ____ No

If yes, please describe areas of your body affected _____

If you are receiving or had radiation therapy, are you experiencing any burns, discoloration, skin peeling or radiation recall? ____ Yes ____ No

If so, where? _____

Do you have any site restrictions due to:

- ❑ incisions, open wounds, drains, or dressings
- ❑ IV, port, ostomy, catheter, or other device *(if yes, circle which)*
- ❑ tumor site
- ❑ neuropathy
- ❑ fracture history
- ❑ other:
- ❑ history or risk of blood clots or phlebitis
- ❑ skin sensitivity, rash, or skin condition
- ❑ radiation site
- ❑ bone or spine metastasis
- ❑ area of infection

Do you have any pressure restrictions due to:

- ❑ history or risk of lymphedema *(if yes, circle which)*
- ❑ area of pain or burning
- ❑ steroid medication
- ❑ fragile veins
- ❑ bone or spine metastasis
- ❑ fragile/sensitive skin
- ❑ fatigue
- ❑ low platelet count

❑ recent surgery

❑ infection or fever

❑ anticoagulants

❑ other:

Do you have any position restrictions due to:

❑ incision ❑ medication ❑ ostomy ❑ difficulty breathing ❑ tender skin

❑ swelling or risk of swelling *(if yes, describe)*:

❑ medical devices *(if yes, describe)*:

❑ discomfort *(if yes, describe)*:

Does any body area need elevating? ____ Yes ____ No

If yes, please describe _____

Has cancer or cancer treatment affected any of the following functions in your body?

❑ lungs ❑ liver ❑ nervous system ❑ heart ❑ kidney ❑ blood counts ❑ energy level

Please describe any you have marked above:

_____

_____

_____

Skin Care History Questionnaire

What concerns you most about your skin today?

Have you ever had an allergic reaction to any skin product or cosmetic? ____ Yes ____ No

If yes, please list _____

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What skin care products are you currently using? _____

_____

Are you currently using any topical or oral medications for your skin conditions or disorders either prescription or over the counter? ____ Yes ____ No

If yes please describe? _____

Are you currently experiencing any skin changes due to your medical oncology therapy?

____ Yes ____ No

If yes please describe? _____

Do you have any excessive dryness, tightness, dry patches or skin peeling? ____ Yes ____ No

Have you noticed any skin discolorations such as light or dark areas? ____ Yes ____ No

If yes where and for how long? _____

Do you have any skin rashes, acne type lesions? ____ Yes ____ No

Is your skin sensitive to temperature changes, burning, itching or pain? ____ Yes ____ No

If yes where and for how long? _____

Do you have any wounds that are not healing? ____ Yes ____ No

If yes please describe: _____

Are you experiencing any issues with your extremities? (Swelling, peeling, redness, pain, itching) ____ Yes ____ No

Have you received any professional skin treatments recently? Such as, chemical or enzyme peels, or microderm, etc. ____ Yes ____ No

How often do you cleanse your face? ___ Once a day ____ Twice a day ____ More often

Do you use an exfoliant? ____ Yes ____ No *If yes, how often?* ____ *times a week*

Do you use a moisturizer? ____ Yes ____ No *If yes, how often?* ____ *times a day*

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Do you use eye cream? ____ Yes ____ No *If yes, how often? ____ times a day*

Do you use sunscreen/sunblock? ____ Yes ____ No

Do you sunbathe or participate in outdoor activities? ____ Yes ____ No

Are you allergic to aspirin? ____ Yes ____ No

Are you allergic to iodine or seaweed? ____ Yes ____ No

Do you use Biore or snore strips? ____ Yes ____ No

Do you or have you ever had acne? ____ Yes ____ No

Are you using or have you ever used any medications for acne? ____ Yes ____ No

If yes, please name the medication: _____

Have you ever had electrolysis or waxing in the past? ____ Yes ____ No

If yes, do you have those services done regularly? ___ Yes ___ No

Have you had permanent cosmetics? ____ Yes ____ No

If yes, where? _____

Have you seen a dermatologist in the past year? ____ Yes ____ No

If yes, list doctor's name and reason for visit: _____

Have you had any of the following?

- ❑ Cosmetic Surgery
- ❑ Botox Injections
- ❑ Skin Cancer
- ❑ Hepatitis
- ❑ Laser Resurfacing
- ❑ Chemical Peels
- ❑ Keloid Scarring
- ❑ Dermatitis

What is it about your skin you would like to change?

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General Signs & Symptoms

Check "yes" or "no" and add comments if you have or have had any of the following:	Yes	No	Comments
Swelling or tendency to swell anywhere in your body			
Sites of pain or tenderness anywhere in your body			
Sites of numbness or reduced sensation anywhere in your body			
Other Medical Conditions			
Skin conditions (rashes, infections, itching)			
Known allergies or sensitivity *(if you use any physician-approved lotion on your skin, please bring it for the massage therapist to use)*			
Cardiovascular conditions *(for example: heart conditions, high blood pressure, angina, hardening of the arteries, history of stroke, severe varicose veins, blood clots)*			
Liver or kidney conditions *(for example: kidney failure, hepatitis, portal hypertension, etc.)*			
Respiratory or lung conditions			
Diabetes *(describe type, any medication, whether blood sugar is well-controlled, any complications)*			
Injuries *(any back problems, knee problems, tendonitis, disc injuries, neck problems, recent fractures)*			
Surgery			

Important note: It is my choice to receive esthetic care. I understand that the information given above is strictly confidential and will be used for no other purpose than to assist the esthetician in providing suitable service(s) which would take into consideration my specific requirements. I also understand that failure to disclose all my known medical conditions could result in injury and/or illness. I hereby release Well Spa and Well of Life Center for Natural Health, LLC, from any claims resulting in such. Any information provided to me by the esthetician is for general purposes only and is not intended for any medical or therapeutic purposes.

Client Signature: _____ Date: _____

AGREEMENT AND RELEASE OF LIABILITY

The health and nutritional information you receive from any Well of Life Center Clinician or employee, or independent contractor, whether given by phone, in person at your home, in a Well of Life Center office, through lectures, workshops, brochures, emails, or newsletters is not intended to diagnose, prescribe, treat, cure, alleviate, prevent or care for any disease in any way. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as client results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a clinician or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. **YOU** are the driving force in guiding yourself on a path to health!

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by the clinicians or employees or independent contractors of the Well of Life Center for Natural Health, LLC is to be used for educational purposes only. I also acknowledge that neither Well of Life Center for Natural Health, LLC, Cynthia Hofmann-Coale, Dr. Vladimir Alhov, M.D., Blossom Soojin Lee, DC, Dr. Charney Slater, D.C., M.S., Sophia Simon, Victoria Fisher, Christine Haines, Alicia Leonhardt, members of the massage department, members of the fitness department, estheticians, nor any of the staff members at the Well of Life Center for Natural Health or Well Spa claim to be medical doctors and will not prescribe for or diagnose, treat, prevent, alleviate or cure any disease or condition. Well of Life Center for Natural Health, LLC and its nutritional clinicians have been thoroughly trained and certified.

If I experience any changes in my health or current medications, I will immediately communicate this information to Well of Life Center for Natural Health, LLC. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Well of Life Center for Natural Health, LLC liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

I understand that Nutrition Response Testing/Autonomic Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Nutrition Response Testing/Autonomic Response Testing is not a method for "Diagnosing" or "Treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Nutrition Response Testing/Autonomic Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing/ Autonomic Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In consideration of being allowed to participate in programs, modalities, and activities of Well of Life Center for Natural Health, LLC. and to use its facilities in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Well of Life Center for Natural Health, LLC and its members, directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, affiliated independent contractors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery. I do also hereby release all of these mentioned and any others acting upon their behalf from any responsibility or liability from any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Well of Life Center for Natural Health, LLC.

I have read and understand the foregoing. Intending to be legally bound, I hereby release the Well of Life Center for Natural Health, LLC from any liability, including for negligence, regarding my health matters and my participation in Nutrition Response Testing/ Autonomic Response Testing or any other program offered at or through the Well of Life Center for Natural Health, LLC. This release applies to all subsequent visits for programs, modalities and activities at the Well of Life Center for Natural Health, LLC.

Client Name (print):_____

Signature: _____ Date:_____

Client, Parent, or Personal Representative