



FACIAL TREATMENT

Client intake form

CLIENT INFORMATION

Name: Date:

Date of birth: Age: Female Male NB

Address:

City: State: Zip:

Phone: Email:

Emergency contact:

How did you hear about us? Social media Google Yelp A friend

Would you like to be added to our email list? Yes No

MEDICAL HISTORY

Do you have any of the following conditions? If yes, please select them:

- | | | |
|--|--|---|
| <input type="radio"/> Acne | <input type="radio"/> Heart disease | <input type="radio"/> Lupus |
| <input type="radio"/> Autoimmune disorders | <input type="radio"/> Hepatitis | <input type="radio"/> Migraines |
| <input type="radio"/> Asthma | <input type="radio"/> Herpes simplex | <input type="radio"/> Phlebitis/blood clots |
| <input type="radio"/> Cold sores, fever blisters | <input type="radio"/> High/low blood pressure | <input type="radio"/> Psoriasis |
| <input type="radio"/> COPD | <input type="radio"/> Hives | <input type="radio"/> Rosacea |
| <input type="radio"/> Cancer | <input type="radio"/> Herpes simplex | <input type="radio"/> Skin infections |
| <input type="radio"/> Diabetes | <input type="radio"/> Hemophilia | <input type="radio"/> Seborrhea |
| <input type="radio"/> Dermatitis | <input type="radio"/> HIV/AIDS | <input type="radio"/> Thyroid condition |
| <input type="radio"/> Eczema | <input type="radio"/> Hyper/hypo pigmentation | <input type="radio"/> Tinea |
| <input type="radio"/> Epilepsy | <input type="radio"/> Hysterectomy | <input type="radio"/> Varicose veins |
| <input type="radio"/> Glaucoma | <input type="radio"/> Keloid, hypertrophic scars | <input type="radio"/> Warts |

Any other condition:

List any medications you take regularly, including vitamins, herbal supplements, aspirin, topicals:

.....
.....

Any known allergies?

No Yes

Any recent surgery, including plastic surgery?

No Yes

FEMALE CLIENTS

Are you pregnant or trying to become pregnant?

No Yes

Are you taking birth control pills?

No Yes

Are you undergoing any hormone replacement therapy?

No Yes

YOUR LIFESTYLE

What is your occupation:

What is your sun exposure?

Never Light Moderate Excessive

Do you use sun protection (sunscreen, hats, protective clothing)?

No Yes

Do you use tanning beds?

No Yes

Do you smoke?

No Yes

Do you drink more than 4 caffeinated beverages a day?

No Yes

What is your alcohol consumption?

None Occasionally Once a week Few times a week Daily

YOUR SKIN CONCERNS

- | | | |
|--|---|---|
| <input type="radio"/> Acne | <input type="radio"/> Facial hair | <input type="radio"/> Razor burn |
| <input type="radio"/> Age spots | <input type="radio"/> Fine lines and wrinkles | <input type="radio"/> Rosacea |
| <input type="radio"/> Blackheads | <input type="radio"/> Hyperpigmentation | <input type="radio"/> Scars |
| <input type="radio"/> Broken capillaries | <input type="radio"/> Ingrown hairs | <input type="radio"/> Skin redness |
| <input type="radio"/> Dark circles | <input type="radio"/> Keratosis pilaris | <input type="radio"/> Sun damage |
| <input type="radio"/> Dehydrated skin | <input type="radio"/> Melasma | <input type="radio"/> Thin skin |
| <input type="radio"/> Dry skin | <input type="radio"/> Milia | <input type="radio"/> Under-eye puffiness |
| <input type="radio"/> Dull skin | <input type="radio"/> Oily skin | <input type="radio"/> Uneven skin texture |
| <input type="radio"/> Eczema | <input type="radio"/> Premature aging | <input type="radio"/> Uneven skin tone |
| <input type="radio"/> Enlarged pores | <input type="radio"/> Psoriasis | <input type="radio"/> Whiteheads |

YOUR SKIN TYPE

- | | | |
|--|---------------------------------------|--|
| <input type="radio"/> Normal skin | <input type="radio"/> Acne-prone skin | <input type="radio"/> Hyperpigmented skin |
| <input type="radio"/> Dry skin | <input type="radio"/> Sensitive skin | <input type="radio"/> Sun-damaged skin |
| <input type="radio"/> Oily skin | <input type="radio"/> Aging skin | <input type="radio"/> Rosacea-prone skin |
| <input type="radio"/> Combination skin | <input type="radio"/> Dehydrated skin | <input type="radio"/> Psoriasis-prone skin |

YOUR SKIN CARE ROUTINE

- | | | |
|--|-----------------------------------|--------------------------------------|
| <input type="radio"/> Eye makeup remover | <input type="radio"/> Eye cream | <input type="radio"/> Facial oils |
| <input type="radio"/> Foam cleanser | <input type="radio"/> Day cream | <input type="radio"/> Mask |
| <input type="radio"/> Gel cleanser | <input type="radio"/> Night cream | <input type="radio"/> Exfoliants |
| <input type="radio"/> Facial soap | <input type="radio"/> Serum | <input type="radio"/> Spot treatment |
| <input type="radio"/> Toner | <input type="radio"/> Sunscreen | <input type="radio"/> Retinols |

YOUR SKIN HISTORY

Have you ever had an allergic reaction to any of the following?

- Alpha hydroxy acids, Animals, Aspirin, Cosmetics, Essential oils, Food, Fragrance, Iodine, Latex, Medication, Nuts, Pollen, Skin products, Shellfish, Sunscreen, Other

If you checked any above, please explain

Are you currently using products containing any of the following ingredients?

- Any exfoliating scrub, Any hydroxy acids (AHAs), Any beta hydroxy acids (BHAs), Vitamin A derivative (i.e. retinol), Renova/Retinoids, Hydroquinone

Any history of previous facials, microdermabrasion, peels or other treatments?

How does your skin heal? Fast, Slow, Scars, Pigments

Do you get bruises easily? No, Yes

Have you ever used or been prescribed any acne medication?

- No, Yes

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

- No, Yes

I have read and completed this questionnaire truthfully. I understand that withholding information or providing inaccurate details about my medical history, allergies, medications, and skincare routines may lead to contraindications or adverse reactions to the treatments I undergo. I agree to inform the technician of any changes in the above information.

Client Name (printed)

Date

Client Name (signature)