Date: _______________

Skin Care & Body Treatment Intake Form

Name: ____ Date of Birth: _____________________________

Address: ____ Gender: Male Female Age: _________

City, State, Zip: ____ Home #: (_______) ________________

Email: ____ Cell #:(_______) __________________

Occupation: ____ Referred by: ______________________________

Emergency Contact: ____ Phone #: (_____) ____________

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1. Allergies:

____

2. Current medications (topical & oral):

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3. Have you ever experienced any of the following conditions? (Please circle all that apply).

Cancer	High/Low Blood Pressure	Metal Implants/Pins	Pacemaker/Defibrillator
Diabetes	Claustrophobia	Heart Disease	Thyroid Disorder
Hysterectomy	Hormone Imbalance	Epilepsy/Seizures	Blush/Redden Easily
AIDS/HIV	Hepatitis A/B/C	Migraines/Headaches	Depression/Anxiety
Psoriasis	Rosacea	Eczema	Bruise Easily
Spinal Injury	Fever Blisters/Cold Sores	Immune Disorders	Lupus
Keloid Scarring	Blood Clot Disorder	Skin Disease/Disorder	Fibromyalgia
Menopause	Eating Disorder	Circulation Disorder	Other: _______________

4. Do you smoke? Y N **5.** Do you wear contacts? Y N **6.** Do you follow a restricted diet? Y N

7. What is your daily consumption of Water? ________ oz. Caffeine? ________ oz. Alcohol? ________ oz.

8. Are you currently under the care of a physician or dermatologist? Y N If so, explain.

____

9. Any surgeries or dental work within the last 6 months? Y N If so, explain.

____

10. Any dermal injections/fillers within the last 6 months? Y N If so, explain.

____

11. (a) Are you using any products that contain Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A, Accutane or any other prescription skin products? Y N

(b) Have you used any of these products in the past 3 months? Y N If so, explain.____

12. Have you ever had any of the following treatments? (Please circle all that apply.) Facial Body Wrap Body Scrub LED Waxing Eyelash/Eyebrow Tinting Microdermabrasion Chemical Peel Dermaplaning Laser Resurfacing

13. Have you ever had any allergic reaction to any skin products? Y N If so, explain:

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14. Do you wear sunscreen daily? Y N

15. What temperature water do you cleanse your skin with? Cold Warm Hot

16. What type of skin care products do you use?

____

17. Female Clients Only: **(a)** Are you currently or trying to become pregnant? Y N **(b)** Are you currently lactating? Y N

(c) Any recent changes to or from your contraceptive treatment? Y N If so, explain.

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Client Consent: I understand, have read, and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the esthetician in giving better service and is completely confidential. The treatments I receive here are voluntary and I release this institution and/or skin care professional from any liability and assume full responsibility thereof.

Client Signature: ____ Date: ____________________

Esthetician Signature: ____ Date: ____________________