Facial, Back Facial, Body Treatment, Makeover Intake Form

Date_____ Referred by_____

Name_____ Birthday_____

Address_____

Cell Phone_____

Email address_____

Married Yes___No___ Anniversary_____Spouse Name & Number_____

Occupation:_____Do you work outdoors? Y___N___

Any known allergies:_____

What are your skin goals:_____

Do you have any special skin problems or concerns pertaining to your face or body? Y___N___

Specify:_____

Have you ever had a chemical peel, laser or microdermabrasion? Y___N___ In the last month Y___N___

Do you use Retin-A, Renova, Alpha Hydroxyl Acid or Retinol/vitamin A derivative products? Y___N___

Have you used any of these products within the last 3 months? Y___N___

Have you used an acne medication? Y___N___ When?_____ Which Medication?_____

Have you used any hair removal methods in the past six weeks? Y___N___ circle all that apply

Shaving Sugar Wax Electrolysis Tweezing Threading Depilatories

What areas of concern do you have:

Breakouts/acne____ Uneven skin tone___ Blackheads/whiteheads___ Sun damage___

Excessive oil/shine___ Wrinkles/fine lines___ Rosacea___ Dull/Dry skin___ Inflammation____

Broken Capillaries___ Flaky skin___ Redness/Ruddiness___ Dehydrated___ Sunspots___

Eyes: Dehydrated___ Wrinkles___ Puffiness___ Dark circles___ Other_____

Lips: Dehydrated___ Cracked/Chapped___ Other_____

Have you ever had an allergic reaction to: (Circle your answers)

Cosmetics AHAs Medicine Fragrance Food_____ Shellfish Animals
Latex Sunscreens Medication iodine Pollen Other Sulfur Soy Seasonal Nuts

What SPF do you use on your face?_____ How often/when?_____

What SFP do you use on your body?_____ How often/when?_____

Have you had any recent tanning bed or sun exposure that changed the color of your skin? Y___N___

Specify_____

Do you smoke Y___N___

Do you have a pacemaker or any pins in bones Y___N___

Have you experienced Botox, Restylane or Collagen injections? Y___N___

Specify_____

Health concerns: circle all that apply: Cancer Diabetes Psoriasis Lupus Arthritis

High/Low Blood Pressure Heart Epilepsy Cold Sores Depression Claustrophobia

Are you under a physician's care for : Acne Rosacea Eczema Psoriasis

Are you wearing contacts today Y___N___

Do you have metal braces? Y___N___

Female clients only: Are you taking oral contraceptives? Y___N___ Specify_____

Are you pregnant? Y___N___

PLEASE REMOVE ALL JEWELRY WHEN CHANGING FOR YOUR FACIAL, THANK YOU

I understand, have read & completed this questionnaire truthfully. I agree that this constitutes full disclosure, & that it supersedes any previous verbal or written disclosures. I understand that withholding information's or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary & I release this institution and/or skin care professionals from liability & assume full responsibility thereof.

Client Signature_____ Date_____