Date: _____

# Skin Care & Body Treatment Intake Form

Name: _____ Date of Birth: _____

Address: _____ Gender: Male Female Age: _____

City, State, Zip: _____ Phone #: (_____) _____ Home

Email: _____ (_____) _____ Cell

Occupation: _____ Referred by: _____

Emergency Contact: _____ Phone #: (_____) _____

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**1. Allergies:** _____

**2.** Current medications (topical & oral): _____

**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: _____

**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. _____

**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: _____