Confidential Client Intake Form

General Information

Name _____ Birthday _____
Address _____
City _____ State _____ Zip Code _____
Phone # _____ Email_____
Occupation_____
Emergency Contact Name _____ Phone # _____
Would you like to be added to our email list for specials and discounts? ▢ Yes ▢ No
How did you hear about us? _____

Medical History

Please check all that apply:

▢ Acne
▢ Depression
▢ Eczema
▢ Fever Blisters
▢ Hepatitis
▢ HIV
▢ Hypo Pigmentation
▢ Low Blood Pressure
▢ Sinus Infection
▢ Pregnant
▢ Rashes
▢ Shingles
▢ Hyper/Hypo Thyroid
▢ Other: _____

▢ Arthritis
▢ Diabetes
▢ Epilepsy
▢ Heart Condition
▢ High Blood Pressure
▢ Hyper Pigmentation
▢ Insomnia
▢ Lupus
▢ Surgery: _____
▢ Psoriasis
▢ Seborrhea
▢ Skin Cancer
▢ Warts

Are you currently taking any medications? ▢ Yes ▢ No
If yes, please explain: _____

Have you had any facial or dermatology services in the past 30 days? ▢ Yes ▢ No
If yes, please explain: _____

Do you have any allergies? ▢ Yes ▢ No
If yes, please explain: _____

Skin Care History

Check the products that you currently use (please select all that apply):

▢ Body Lotion
▢ Body Scrub
▢ Day Cream

▢ Body Soap
▢ Cleansing Cream
▢ Eye Makeup Remover

☐ Eye Cream ☐ Exfoliants
☐ Facial Soap ☐ Facial Scrub
☐ Hand Cream ☐ Neck Cream
☐ Night Cream ☐ Skin Toner/Astringent
☐ Other: _____

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache
☐ Inflammation ☐ Insomnia ☐ Muscle Cramps ☐ Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐ Acne/Breakouts ☐ Blackheads/Whiteheads
☐ Broken Capillaries ☐ Clogged Pores
☐ Dark Spots ☐ Dryness
☐ Excessive Oil/Shine ☐ Redness
☐ Rosacea ☐ Scarring
☐ Sun Damage ☐ Uneven Skin Tone
☐ Unwanted Hair ☐ Wrinkles/Fine Lines
☐ Other: _____

Have you been under the care of a dermatologist within the past year? ☐ Yes ☐ No
If yes, please explain: _____

Have you used Retin-A, Renova, AHAs or Retinal/Vitamin A products in the last three months?
☐ Yes ☐ No
If yes, please explain: _____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?
☐ Yes ☐ No

By signing below, I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damage incurred due to any misrepresentation of my health.

Name Printed Signature Date

_____ _____ _____