

Client Intake Form
Skin Therapies

Name: _____ **Date:** _____

Address: _____
Street City State Zip Code

Phone Number: _____ **Email:** _____
Home/Mobile/Work (circle type)

Would you like to subscribe to The Tranquil Butterfly Newsletter/Updates: YES No

Skin Type circle one: **Normal Dry Oily Combination Acne Sensitive**

Skin Concerns circle all that apply:

Fine lines Wrinkles Dehydration Hyper/Hypo Pigmentation Blackheads. Milia Scars Broken Capillaries
Other: _____

Skin Conditions circle all that apply:

Rosacea Cold Sores Eczema Psoriasis Warts Dermatitis
Other: _____

Current Treatments Check all that apply and input date of last treatment:

___ Electrolysis ___ Laser ___ Chemical Peel ___ Waxing ___
___ Cosmetic Surgery ___ Depilatories ___ Microdermabrasion ___
___ Microneedling/CID ___ Botox ___ Fillers ___
___ Other _____

Current Homecare Skin Regimen: Please state brand and when used: daily, x per wk, am/pm

Facial Cleansers: _____ Toners/Mists: _____
Serums: _____ Moisturizers: _____
Exfoliants: _____ Masks: _____
Dermatologist Prescriptions: _____
Other: _____

Health Information

Are you pregnant or trying to become pregnant? YES NO

Do you take (circle all that apply): Birth Control Hormone Replacement Therapy Biodynamic Hormones

Please list all medications and supplements you are currently taking:

Recent Radiation or Chemotherapy: YES NO

Recent Surgery (Date) _____

Do you have or have you had in the past any allergic reactions to any specific ingredients or product lines?

Please specify _____

Any Food Allergies? YES NO. If YES please specify:

Do you Smoke? YES NO

How many ounces of water do you consume daily: _____ oz.

Do you exercise? YES NO How often? _____

Your last sunburn? _____ Do you use a tanning bed? YES NO

Is there anything else you believe we should be aware of in regards to your health? Please specify: _____

Client Consent

I voluntarily elect to undergo the following Skin Therapy: _____.

I have, to the best of my knowledge, given an accurate account of my medical history including all known allergies or prescription drugs or products that I am currently ingesting or using topically. I have also disclosed all cosmetic procedures that I have recently undergone.

Signature:

Client Signature: _____ Date: _____

Esthetician Signature: _____ Date: _____