Beauty Journey, LLC

Please answer these questions to help us provide the best service for your skin.

Client Intake Form

Name: _____

Address:_____**Apt#**____ **City**_____**State**___**Zip** _____
Telephone: (Primary)_____**(Alternate)** _____
E-mail Address: _____
Birthday: _____ under 21 21-30 31-40 41-50 51-60 60-65 70+
How did you hear about us? _____

1. **Have you had any of these health problems in the past or present?**
   Cancer Diabetes Epilepsy Heart problem Hysterectomy Systemic Disease
   Hormone Imbalance Spinal Injury Thyroid Condition Varicose Veins HIV/AIDS
   Hepatitis Other
   _____
2. **What skin care products are you currently using?**
   Cleanser Toner Exfoliation Serum Eye Cream Moisturizer Sunscreen Masque
3. **Have you ever had peels, laser, light therapy, microdermabrasion, wax, dermaplane or any other resurfacing treatment?**
   Yes No

   If yes, which one & when was the last time you had the treatment? Did you have any complications?

   _____
   _____
4. **Are you on any prescription skin medication?** Yes No

   If yes, please list them here:

   _____
5. **Are you currently using any products that contain the following ingredients?**
   Glycolic acid Lactic acid Salicylic acid Other Hydroxy Acids Vitamin A derivatives (i.e. Retinol)
6. **What type of massage pressure do you prefer?** Soft Medium Firm
7. **What is your skin care goals?** Acne/Deep Cleansing Reduce Pigmentation Anti-Aging

   Additional notes or instructions: _____
   _____
8. **If extractions are needed, how many would you like done?** None Light Medium
   Leave to the discretion of my therapist.

9. **Have you ever had a reaction to any of the following?**
   Cosmetics Medicine Essential oils Pollen Food Hydroxy acids Sulphur Fragrance Other

   _____

10. **List any medications, supplements, vitamins, diuretics, slimming pills, oral contraceptives, Isotretinoin, etc. that you take regularly**

    _____

11. **Have you used Retin-A, Renova, Adapalene or any other prescription skin products within the last 3 months?** Yes No

12. **Are you pregnant, trying to become pregnant or lactating?** Yes No

13. **Do you have metal implants, a pacemaker or body piercing?** Yes No

14. **Do you have sinus problems?** Yes No

15. **Do you wear lenses?** Yes No

16. **Have you ever experienced claustrophobia?** Yes No

Please read the following information:

This Intake form is used to evaluate your individual skin care needs. We will maintain the confidentiality of this information, and will disclose this information only to our staff members to qualify assurance and quality control personnel, to our product supplier and manufacturer. We will not provide this information to anyone else, except as required by law, and we will not sell this info to anyone. We, however, contact you with product-related information.
I confirm (to my best knowledge) that the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I also affirm to keep the practitioner updated as to any changes in my medical profile.
I understand that the skin care service I receive is provided for the basic purpose of relaxation, skin care, and/or waxing. I understand that some redness/irritation is possible, and to ask my practitioner about follow-up care. If I experience any pain or discomfort during this session, I will immediately inform her. I understand that there shall be no liability on the practitioner's part should I fail to do so. I do hereby waive, release and forever discharge Beauty Journey, LLC/ Leah Cohen from any and all responsibility or liability related to my service.

Client Full Name: _____

Client Signature: _____Date: _____

Photographic Consent: I consent to photographs being taken before, during and after each procedure. I agree to these photos being stored electronically in my case file and will be used only with my written consent for promotional purposes.

Client Signature: _____Date: _____