Permanent Cosmetics Client Intake

Today's Date: _____

Client's Legal Name: _____

Date of Birth: _____ Drivers License/ID# (Required proof for state of CA laws): _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: _____ Email: _____
How did you hear about us (internet search/social media/friend (list name)?: _____
In case of emergency, notify (name/phone number): _____

Confidential history

Are you currently using or taking (check all that apply):

Accutane/Isotretinoin in the past 12 months ☐	Retin-A/Renova ☐	☐ Smoker ☐
Prescription Pain Relievers ☐	Glycolic, Beta or Alpha Hydroxy Acids (AHA / BHA) in skin care ☐	Chemical Peels ☐
Steroids or Immunosuppressants ☐	Retinols in skin care ☐	Latisse or lash/brow growth serums ☐
Antibiotics in the past 2 weeks ☐	Indoor/Outdoor Tanning or Sunburn in the past 2 weeks ☐	Hormone Replacement ☐
Blood thinning medications or daily Aspirin use ☐	Any acne medications or Vitamin A derivatives ☐	Contraceptives ☐
Mood altering medications ☐	Contact Lenses ☐	

Confidential Health information (check all that apply):

Diabetes ☐	High/Low Blood Pressure ☐	Hemophilia/Bleeding disorder ☐
Heart problems ☐	Seizures or Epilepsy ☐	Eczema ☐
Pacemaker ☐	Currently pregnant or Nursing ☐	Psoriasis ☐
Current or Recent Cancer Treatments ☐	Cold Sores/Fever Blisters ☐	Rosacea ☐
Staph/MRSA ☐	Herpes virus ☐	☐ Keloids (raised scars) ☐
Glaucoma ☐	Autoimmune disorders ☐	Claustrophobia ☐
Ocular Herpes ☐	Hypo-pigmentation (lightening of the skin) ☐	Any problems healing ☐
Dry eyes ☐	Hyper-pigmentation (darkening of the skin) ☐	

• Additional details or other health issues not listed above:

_____

_____

• Are you under the care of a Physician or Dermatologist? ☐YES ☐NO

• Are you required to take a course of antibiotics for any minor dental or medical procedures? ☐YES ☐NO

• Do you have problems getting numb at the dentist? ☐YES ☐NO

• List any medications, supplements, vitamins or herbs that you take regularly:

_____

_____

Do you have allergies or sensitivities to (check all that apply): Latex ☐ Products containing "Caine" – Microcaine, Lidocaine, Tetracaine ☐ Medications ☐ Nickel or other metals ☐ Bacitracin or Neosporin ointment ☐ Petroleum products ☐ Fragrances ☐ Skin Care Ingredients ☐ Essential Oils ☐

• List all known allergies and reactions:

_____

• Have you received Botox/Dysport or fillers such as Juvederm/Restylane treatments in the past 30 days? ☐YES ☐NO If yes, when? What areas?:

_____

• Have you received a chemical peel, microdermabrasion, IPL, laser or other facial skin resurfacing treatment in the past 30 days? ☐YES ☐NO If yes, when?: _____ • Do you have previous or existing Permanent Makeup? ☐YES ☐NO If yes, where?

_____

• Are you requesting that a new procedure be performed over previous or existing Permanent Makeup? ☐YES ☐NO

• Have you had any complications with previous tattoos or permanent makeup? ☐YES ☐NO If yes, what complications?:

_____

• Have you been advised by your doctor not to undergo any form of tattooing? ☐YES ☐NO

• How often are you exposed to the sun, whether during work or at play?:_____

• How often do you wear sunblock?: _____

• What is your skin tone? Very Fair ☐ Medium ☐ Dark ☐ Fair ☐ Medium-Olive ☐ Very Dark ☐

• What is your hereditary background to help us choose pigment colors? (circle all that apply) Nordic / Scandinavian / Irish / English / Asian / Mediterranean / Hispanic / Native American / Middle Eastern / African American / Other:

_____

• What do you believe best describes your skin type? (check all that apply): Dry ☐ Normal/Combination ☐ Oily ☐ Sensitive ☐

• Is there anything else we need to know about you in order to better service your needs?:

_____

Thank you for taking the time to complete this client intake form. All of the information above is extremely helpful to provide the best care for you and ensure your safety during the procedure.

Read and initial the below:

• I understand that full disclosure of my past and current health history is in my best interest to ensure a safe procedure and that I have honestly disclosed such information. (initial) ____

• I understand if I change my skin care routine or medications, or my health condition changes, I must inform the professional PRIOR to any service in the future. (initial) _____

• I understand that if I have health or medication contraindications the technician may require a written release from my Physician before proceeding with any procedure. (initial) ____

Today's Date: _____

Client Printed Name: _____