Patient Intake Form

Name: ____ **DOB**: __ __ / __ __ / __ __
Preferred Name:____________________________________ **Pronouns:**_________________
Address: ____
City: ______________________________________ **State**: _________ **Zip**: _______________
Home Phone: ______________________ **Cell**:_______________________
Email:_____________________________________

Emergency Contact: ______________________________ **Phone**: _______________________
Relationship: ______________________

Primary Physicians Name:_________________________ **Phone:** ________________________
City/State:________________________________
Pharmacy:_________________________ **Phone:**_______________ **Location:**_____________

How did you hear about us?____

Medical History

Have you ever had/currently have any of the following conditions? (check all that apply)

▢ Bleeding problems
▢ Cancer
▢ HIV/AIDS
▢ Kidney disease
▢ Hirsutism
▢ Neurological disease
▢ Breathing problems
▢ Unusual moles
▢ Epilepsy/Seizures
▢ Chemotherapy/Radiation
▢ Stroke
▢ Heart Condition
▢ Migraines
▢ Eaton Lambert Syndrome
▢ Musculoskeletal issues
▢ Keloid scarring
▢ Fainting spells
▢ Diabetes
▢ Blood Disorders
▢ Endocrine/hormonal imbalance
▢ Autoimmune disorder/condition
▢ Dysphagia
▢ Eczema/Psoriasis
▢ Arthritis
▢ Other: ______________________________
▢ If yes to any of the above, please be specific:__________________________________
____

Allergies (medications, cosmetics, latex/other):

____
____
____

List all current medications/supplements:
(prescription, over-the-counter, topical, vitamins, etc)

____
____
____

List all other health concerns (diseases/illnesses)**:** ______________________________________
____

Are you pregnant/planning to become pregnant? Y N
Are you breastfeeding? Y N
Do you have any metal implants? Y N
If yes, where?______________________________________
Do you have a pacemaker? Y N
Do you smoke/use tobacco products? Y N
If yes, how much?_________________________________
Do you or have you had cold sores/herpes? Y N
If yes, where and how long ago/how often?__________________________
Do you have any tattoos/permanent makeup? Y N
If yes, where?______________________________________
Have you had any recent tanning, use of self-tanning lotions or sun exposure? Y N
If yes, please explain:______________________________
Is your skin sensitive to sunlight/heat? Y N
Do you bruise easily? Y N
Do you have any active skin infections/open lesions? Y N
If yes, where?__________________________________
Have you ever had laser hair removal/electrolysis? Y N
If yes, how long ago/last treatment date?____________________
Have you ever had injectable neurotoxin (Botox, Dysport, Xeomin)**? Y N**
If yes, how long ago/last treatment date?____________________
Have you ever had injectable filler (Juvéderm, Restylane, etc.)**? Y N**
If yes, where and how long ago?_____________________________
Have you ever had or are currently receiving Gold therapy? Y N
If yes, when was your last treatment?________________________
Have you taken Accutane in the last 6 months? Y N

Skin Evaluation:

Which of the following best describes your skin type?

- ▢ 1. Always burn, never tan
- ▢ 2. Always burn, sometimes tan
- ▢ 3. Sometimes burn, always tan
- ▢ 4. Rarely burn, always tan
- ▢ 5. Brown, moderately pigmented skin
- ▢ 6. Heavily pigmented skin, very dark

What is your skin care regimen?____
____
____
____

ACKNOWLEDGEMENT

BY MY SIGNATURE BELOW, I CERTIFY THAT ALL INFORMATION IS CORRECTLY DOCUMENTED TO THE BEST OF MY KNOWLEDGE, AND I WILL UPDATE MY MEDICAL HISTORY WITH CURRENT CHANGES.

Print Name:_____________________________________

Patient Signature:________________________________ **Date:**________________

Vermont Medical Spa
P: 802.876.7378
F: 802.662.4117
vtmedspa@gmail.com

Vermont Medical Spa Policy Agreement

______(initial) VMS strives to deliver an excellent experience and the best service possible. In order to achieve this, we are conscientious of everyone's time and availability. Please provide a 24-hour notice if you need to cancel or reschedule your appointment. If you cancel outside of the 24-hour notice window or no-show your appointment, you will be automatically charged a $50 cancellation fee.

______(initial) I understand that VMS can not guarantee an exact number of treatments needed to satisfy clients expectations. Every client can vary depending on many considerations.

______ (initial) I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the service provider of my current medical, and health conditions, aesthetic treatments, and skincare changes to update this history. A current medical history is essential for the practitioner to execute appropriate treatment procedures.

______(initial) I understand that payment is due in full at the time of treatment. Services and products are non-refundable.

______(initial) I understand that VMS requires before and after photographs for specific treatments.

_____(initial) I understand that services provided at Vermont Medical Spa are elective treatments. I understand the risks associated with the treatments that will be provided to me. I hereby

Photographic documentation will be taken before and after treatments.
I do___do not___authorize the use of my photographs for teaching and/or marketing use.

ACKNOWLEDGEMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE VERMONT MEDICAL SPA'S PRACTICE POLICIES AND AGREEMENTS. I CERTIFY THAT ALL INFORMATION IS CORRECTLY DOCUMENTED TO THE BEST OF MY KNOWLEDGE.

Patient Signature:______________________________ **Date:_______________**

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