



Intake Form- Skin Care

First and last name _____ Date _____
Address _____ City _____
State _____ Zip Code _____ Phone number _____
Email _____ Birthdate _____
Occupation _____ Emergency Contact _____
Phone # _____ Relationship _____

-Have you received a facial treatment before? Yes ___ No ___, When? _____

-Have you received any of the following services?

Microdermabrasion _____ Chemical Peel _____ Dermaplaning _____ Laser _____

Botox or collagen injections _____ Waxing _____ Permanent hair removal _____

Massage _____ Body treatments _____

Any of these services in the last month? Yes ___ No ___, Which ones? _____

-What are your primary goals for this treatment? _____

-What areas of concern do you have regarding your skin: (Please check all that apply)

Breakouts/Acne _____ Uneven skin tone _____

Blackheads/Whiteheads _____ Sun damage _____

Excessive oil/Shine _____ Wrinkles/Fine Lines _____

Rosacea _____ Dull/Dry skin _____

Broken capillaries _____ Flaky skin _____

Redness _____ Dehydrated _____

Sun spots _____ Scaring _____

Overly sensitive/ Reactive _____ Other _____

Eyes: Wrinkles _____ Puffiness _____ Dark Circles _____ Other _____

-Please describe your current skin care routine and the brands used, to the best of your knowledge _____

-Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? Yes____ No____

-Have you used any of the products in the last 3 months? Yes____ No____

-Have you used an acne medication? Yes____ No____ When?_____ Which drug?_____

-Do you have allergic reactions to any products, oils, fragrances, nuts, seeds etc? If yes, please identify and explain_____

-Have you had any recent tanning bed or sun exposure that changed the color of your skin? Please specify_____

-How much water do you drink per day?_____

-Do you smoke? Yes____ No____

-How do you rate your eating habits? Very healthy____, Moderately healthy____, Needs improvement____, or Poor____?

-Do you take nutritional supplements? Yes____ No____ Which types?_____

-Please describe the type and frequency of exercise you engage in _____

-Hobbies and interests_____

(Females only)

-Are you taking oral contraceptives? Yes____ No____

-Are you pregnant or breastfeeding? Yes____ No____

-Are you undergoing hormone replacement therapy? Yes____ No____

Client Agreement

-I understand that this service is not a substitute for medical evaluation or treatment.

-I freely give my permission for the therapy received.

-I am responsible for informing my therapist of any relevant medical conditions or concerns, and will keep my therapist updated if there are any changes at my future appointments.

-I take full responsibility for this treatment and for the healing that occurs, and understand that there could be some discomfort and soreness in the healing process.

-I am responsible for paying for any appointment I miss or cancel with less than 24 hours notice.

-I have read, understand, and agree to all the terms above. By signing below I agree to hold harmless Annie Ritter and Illumine Skin and Wholeness Spa for this treatment and any future services I receive with this business.

Signature_____ Date_____