CONFIDENTIAL CLIENT INTAKE FORM

General Information

Name ____ Birthday ____________
Address ____
City ____ State __________ Zip Code __________
Phone # _________________________ Email____
Occupation ____
Emergency Contact Name ________________________________ Phone # __________________
Would you like to be added to our email list for specials and discounts? Yes No
How did you hear about us? ____

Medical History

Please check all that apply:

Acne	Arthritis	Depression
Diabetes	Eczema	Epilepsy
Fever Blisters	Heart Condition	Hepatitis
High Blood Pressure	HIV	Hyper Pigmentation
Hypo Pigmentation	Insomnia	Low Blood Pressure
Lupus	Sinus Infection	Surgery: __________
Pregnant	Psoriasis	Rashes
Seborrhea	Shingles	Skin Cancer
Hyper/Hypo Thyroid	Warts	Other: ____________

Are you currently taking any medications? Yes No
If yes, please explain: ____

Have you had any facial or dermatology services in the past 30 days? Yes No
If yes, please explain: ____

Do you have any allergies? Yes No
If yes, please explain: ____

Skin Care History

Check the products that you currently use (please select all that apply):

Body Lotion	Body Soap	Body Scrub
Cleansing Cream	Day Cream	Eye Makeup Remover
Eye Cream	Exfoliants	Facial Soap
Facial Scrub	Hand Cream	Neck Cream
Night Cream	Skin Toner/Astringent	Other: ____________

What type of skin do you have?

Normal Oily Dry Combination Unsure

Conditions you are currently experiencing today (please select all that apply):

Anxiety	Fatigue	Forgetfulness	Headache
Inflammation	Insomnia	Muscle Cramps	Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

Acne/Breakouts	Blackheads/Whiteheads
Broken Capillaries	Clogged Pores
Dark Spots	Dryness
Excessive Oil/Shine	Redness
Rosacea	Scarring
Sun Damage	Uneven Skin Tone
Unwanted Hair	Wrinkles/Fine Lines
Other: ____________________	

Have you been under the care of a dermatologist within the past year? Yes No

If yes, please explain: ____

Have you used Retin-A, Renova, AHAs or Retinal/Vitamin A products in the last three months?

Yes No

If yes, please explain: ____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

Yes No

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
__________________________	__________________________	__________