FACIAL INTAKE FORM

CLIENT INFORMATION

Name:	Sex

Address:

City:	State:	Zip Code:

Phone #:	Occupation:

Email:	D.O.B

MEDICAL HISTORY

Please check all that apply:

☐ Acne	☐ Fever	☐ Loss of Sensation	☐ Skin Cancer
☐ Arthritis	☐ Fungal Condition	☐ Low Blood Pressure	☐ Skin Conditions/ Disorders
☐ Asthma	☐ Headaches/Migraines	☐ Lupus	☐ Stress
☐ Bleeding Disorder	☐ Heart/Liver/Kidney Disease	☐ Organ Failure	☐ Stroke
☐ Cancer/Chemotherapy/ Radiation	☐ Hepatitis	☐ Plastic/Bone Cement/ Metal Implants	☐ Surgery
☐ Cardio/Vascular Issues	☐ High Blood Pressure	☐ Pre-Cancerous Lesions	☐ Transplant(s)
☐ Dermatitis	☐ HIV	☐ Pregnant/Breast Feeding	☐ Unhealed Wounds
☐ Diabetes	☐ Hives/Herpes/Shingles	☐ Psoriasis	☐ Vertigo/Dizziness
☐ Depression	☐ Hyper/Hypo Thyroid	☐ Rashes	☐ Warts
☐ Easily Bruises/ Sensitive Skin	☐ Hypertension	☐ Recent Surgical Incisions	☐ Watery Eyes/ Seasonal Allergies
☐ Eczema	☐ Inflammation	☐ Respiratory Conditions	☐ Other ________
☐ Epilepsy/Seizures	☐ Insomnia	☐ Seborrhea	________
☐ Fatigue	☐ Keloid Scarring	☐ Sinus Infection	________

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please explain:

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain:

Do you smoke, consume alcohol or caffeine? ☐ Smoke ☐ Alcohol ☐ Caffeine ☐ None

Turn Over -->

SKIN CARE HISTORY

Please describe your skin type:

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Have you had any facial or dermatology services in the past 30 days? ☐ Yes ☐ No

If yes, please explain:

Have you used any Bleaching, Retin-A, AHAs or Retinol/Vitamin A products in the last 90 days? ☐ Yes ☐ No

If yes, please explain:

Have you had any Botox, Restylane, Juvederm or any Collagen injections within the last 6 months? ☐ Yes ☐ No

If yes, please explain:

Any history of Accutane (isotretinoin) use? ☐ Yes ☐ No

If yes, please explain:

Do you frequently use tanning beds or have had any excessive sun/UV exposure within the last 4 weeks? ☐ Yes ☐ No

If yes, please explain:

Please list the products you are currently using in your skin care routine:
Be as specific as you can with the brands/names/ingredients.

SKIN CONCERNS

Please check all that apply:

☐ Acne	☐ Dryness/Dull Skin	☐ Milia	☐ Sensitivity
☐ Blackheads	☐ Eczema	☐ Oily Skin	☐ Sun Damage
☐ Broken Capillaries	☐ Fine Lines/Wrinkles	☐ Psoriasis	☐ Thin
☐ Comedones	☐ Hyperpigmentation	☐ Redness	☐ Unwanted Hair
☐ Cherry Angioma	☐ Hypopigmentation	☐ Rosacea	☐ Other ________
☐ Discoloration	☐ Keloids	☐ Scarring	________

How did you hear about us?:

I understand that this form and it's data are completely confidential. The information I have provided regarding my medical history is accurate to the best of my knowledge, and I affirm I do not have any ailments or conditions that would make this treatment/procedure incompatible with my health and wellbeing. By signing this form, I certify that I am at least 18 years of age and fully competent to give my consent; that I have been given the opportunity to ask any questions I may have, and those questions have been answered. I acknowledge the information given to me pertaining to the requested treatment(s)/procedure(s), and I have been sufficiently informed of the benefits and risks involved. I agree to inform my Esthetician/Technician if I experience any pain, discomfort, or sensitivities during treatment, allowing for them to make the appropriate adjustments. I agree to waive all liability towards my Esthetician/Technician and Serene Society Nail Bar & Day Spa, for any possible harm or injury in the case of my failure to disclose any and all/past and present health conditions.

Client Signature: Esthetician Signature: Date: