Soigné Aesthetics
Skin & Brow Studio

Intake & Consultation

Name: _____ Date Of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Is it ok to text this number? ❑ Yes ❑ No

E-Mail: _____

DAILY FACTORS:

1. Are you a smoker? ❑ Yes ❑ No

2. Are you pregnant? ❑ Yes ❑ No

3. Are you currently under the care of a physician? ❑ Yes ❑ No

If yes, for what condition(s)? _____

Do you have any allergies? _____

Have you ever been diagnosed with or treated for any of the following within the last 24 months? (Check all that apply)

❑ Eczema ❑ High Blood Pressure ❑ Cancer ❑ Psoriasis ❑ Claustrophobia ❑ Epilepsy

❑ Acne ❑ Hormone Therapy ❑ Cold Sores ❑ Diabetes ❑ Cardiac Issues ❑ Blood Clots

❑ Keloids ❑ Pacemaker ❑ Anemia ❑ Other _____

Current medications and/or supplements? _____

_____

Daily stress level: ❑ Mild/Low ❑ Medium/Average ❑ High/Intense

Occupation: _____

How much water do you drink per day? _____ Do you exercise regularly? ❑ Yes ❑ No

Do you have any metal implants in your body? ❑ Yes ❑ No

If yes, where? _____

YOUR SKIN:

What is the primary reason for your visit? _____

What is the most important improvement you would like to see in your skin? _____

Please list any cosmetic procedures you have had in the last 12 months _____

How often do you wear sunscreen? ❑ Every Day ❑ Occasionally ❑ Only when I'm outside

Have you received any of the following procedures within the last 6 months? (Check all that apply)

❑ Microdermabrasion ❑ Facial Injections (Botox, Fillers) ❑ Dermaplane ❑ Waxing

❑ Laser Procedures ❑ Microneedling (CIT, PRP) ❑ Chemical Peels

❑ Other _____

What skincare line(s) are you using? _____

Current Routine (list all that apply):

❑ Cleanser _____ ❑ Exfoliant _____

❑ Toner _____ ❑ Serum(s) _____

❑ Mask(s) _____ ❑ Eye Cream _____

❑ Moisturizer _____ ❑ Sunscreen _____

❑ Other _____

Have you used any of the following in the last 12 months? (Check all that apply)

❑ Accutane ❑ Retin-A ❑ Renova ❑ Topical Antibiotics ❑ Differin ❑ Tazarac ❑ Other _____

I understand that the information I have provided is true and correct. I also understand that all information stated is strictly confidential and will not be shared outside of this facility due to HIPPA regulations.

Signature _____ Date _____

Fitzpatrick Scoring Test

Genetic Disposition Score	0	1	2	3	4
What color are your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is your natural hair color?	Sandy Red	Blonde	Chestnut/ Dark Blonde	Dark Brown	Black
What is your skin color? (non-exposed areas)	Reddish	Very pale	Pale with beige tint	Light Brown	Dark brown
Do you have freckles on non-exposed areas?	Many	Several	Few	Incidental	None

Total Score for Genetic Disposition:_____

Reaction to Sun Exposure Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes then peels	Rarely burns	Never burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem

Total Score for Reaction to Sun Exposure:_____

Tanning Habits Score	0	1	2	3	4
When were you last exposed to sun (artificial sun lamp/spray tan/creams)	Over 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Score for Tanning Habits:_____

TOTAL SCORE	FITZPATRICK TYPE
0-7	I
8-16	II
17-25	III
26-30	IV
Over 30	V-VI

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Informed Consent Form

Name:_____ Date:_____

The instructions and guidelines provided in this informed consent should be followed by all individuals receiving a professional service. Please read and initial after each paragraph acknowledging that you have read and understand all the information presented.

PROFESSIONAL AESTHETIC IN-CLINIC SERVICE

1. This professional aesthetic in-clinic service is designed to improve the texture and appearance of your skin. Your participation in your service will determine the outcome. It is important that you strictly adhere to all instructions that your aesthetician will provide.
2. Depending on the service, you may experience some temporary erythema (redness), irritation, or warm flushing. During the next few hours, you experience some tightening of the skin which may last for several days.
3. For some individuals, a light flaking begins within 48 hours. It is impossible to predetermine how much flaking will occur.
4. Depending on the service, the sloughing process usually subsides within 2-7 days.
5. Pigment may appear darker on the surface before fading.
6. Lack of flaking or "peeling" is NOT an indication that the service was unsuccessful. If you do not notice actual peeling, you are still receiving all the benefits of your service such as improvement of skin tone, texture, and appearance of fine lines and hyperpigmentation. There are a number of reasons why some people may not experience peeling.
7. Results may vary with each service and individual client.

I CAN CONFIRM THAT THE FOLLOWING ARE ALL TRUE:

- ❑ I am NOT pregnant
- ❑ I have had NO sunburns in the last 7 days
- ❑ I am NOT allergic to aspirin
- ❑ I do NOT have active cold sores
- ❑ I have NOT taken Accutane (or it's generic form) within the last 6 months
- ❑ I have experienced NO new allergies or sensitivities since my last visit

PRE-SERVICE GUIDELINES –(unless otherwise instructed to do so by your skin therapist:)

____ 1. I confirm that I have followed the pre-service guideline of: avoiding waxing, electrolysis, laser hair removal, prescription retinoids/retinoid-like compounds (Retin-A, Renova, Differin, Tazorac), products containing any exfoliating agents that may sensitize the skin, for one week prior to service.

____ 2. I confirm that I have advised my aesthetician of any medical cosmetic facial procedures within the last 14 days.

POST-SERVICE GUIDELINES -(post care is the continuation of your in-clinic service)

____ 1. It is essential to follow the post-service home care program as recommended by your aesthetician. Including daily SPF protection.

____ 2. Avoid direct sun exposure, strenuous exercise, or high amounts of heat, including saunas and hot tubs.

____ 3. Do not pick or pull the skin.

____ 4. Immediately notify your aesthetician of any concerns.

CONSENT

I hereby give my consent and authorization, and voluntarily release_____from any claims implied or stated that I from any claims implied or stated that I have or may have in the future with this service, regardless of result. I am stating that the service and precautions above have been explained to me in detail and that I fully understand. If I am under the care of a physician, I have discussed the service plan with my physician for prior approval.

Signature _____ *Date* _____

Soigné Aesthetics
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Model/Photo/Video Release

Date: _____

I hereby irrevocably consent to and authorize the use and reproduction by Soigné Aesthetics dba Ashley Jenkins or anyone authorized by you, of any and all photographs or video/film, which you have taken of me for any purpose whatsoever, without further compensation to me. All images and/or video/film/digital assets shall constitute your property, solely and completely.

Model Name _____

Model Signature _____

Address _____

City _____

State/Zip _____

Phone (_____) _____

Signature of Parent or Guardian if Model is a minor _____

Witnessed by _____

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Cancellation Policy

Cancellation & No-Show Policy

The following cancellation and no-show policy has been created to ensure mutual respect for your time and mine. I aim to provide every client with a personalized and positive experience.

When you schedule an appointment, the time is allocated for you exclusively.

I recognize that schedule adjustments may be necessary. If you need to cancel or reschedule your appointment, I need the following from all clients:

CANCEL OR RESCHEDULE APPOINTMENTS A MINIMUM OF 24 HOURS IN ADVANCE

This will give us the opportunity to schedule another client.

On the day of your appointment, or within 24 hours of your appointment, 40% of the booked service(s) will be charged for cancellations.

75% of the original cost of the booked service(s) will be charged as a "No-Show" fee to clients who do not arrive for their scheduled appointment.

All clients who arrive more than 10 minutes after their scheduled appointment time, may be requested to reschedule and be charged 40% if there is insufficient time to conduct the scheduled service(s).

No-Show and cancellation costs will be charged to the credit card on file, or will need to be paid before being able to schedule another appointment. After this fee has been processed, you will be able to make a new appointment. If your card is declined, a hold will be placed on your client profile. Thank you so much for your understanding, I truly value your business.

I have read and understand the Cancellation & No-Show Policy and agree to comply by its terms. I consent to pay any cancellation fee's I may incur.

_____ _____

Client Printed Name Client Signature

_____

Date