Confidential Client Intake Form

Shannon Browning SKIN & BODY

General Information

Name | Date of Birth

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
- ☐ Diabetes
- ☐ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hypo Pigmentation
- ☐ Lupus
- ☐ Pregnant
- ☐ Seborrhea
- ☐ Hype/Hypo Thyroid
- ☐ Arthritis
- ☐ Eczema
- ☐ Heart Condition
- ☐ HIV
- ☐ Insomia
- ☐ Sinus Infection
- ☐ Psoriasis
- ☐ Shingles
- ☐ Warts
- ☐ Depression
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Hyper Pigmentation
- ☐ Low Blood Pressure
- ☐ Surgery:
- ☐ Rashes
- ☐ Skin Cancer
- ☐ 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
- ☐ Cleansing Cream
- ☐ Eye Cream
- ☐ Facial Scrub
- ☐ Night Cream
- ☐ Body Soap
- ☐ Day Cream
- ☐ Exfoliants
- ☐ Hand Cream
- ☐ Skin Toner/Astringent
- ☐ Body Scrub
- ☐ Eye Makeup Remover
- ☐ Facial Soap
- ☐ Neck Cream
- ☐ 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 ☐ Insomia ☐ 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

Client Consent Form & Liability Waiver

I hereby consent to and authorize Shannon Browning AES, LMT to perform the following procedure:

_____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment have been explained to me.

I understand and acknowledge that there are risks involved with the treatment I will be receiving. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understood the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

_____	_____	_____
Printed Name	**Signature**	**Date**
Shannon Browning AES, LMT	_____	_____
Esthetician Name	**Signature**	**Date**

Covid-19 Liability Release Form

Due to COVID-19, we are taking extra precautions with each client and have improved our sanitation and disinfecting practices. Please complete the following and sign below.

☐ I confirm that I, nor anyone in my household have any of the following symptoms of COVID-19 listed below, nor have had any of the following symptoms in the past 14 days:

☐ Fever	☐ Body aches
☐ Chills	☐ Headache
☐ Cough	☐ New loss of taste or smell
☐ Shortness of breath	☐ Sore throat
☐ Difficulty breathing	☐ Congestion or runny nose
☐ Fatigue	☐ Nausea or vomiting
☐ Muscle aches	☐ Diarrhea

☐ To the best of my knowledge, neither I nor anyone in my household has been in contact with anyone who has tested positive for COVID-19._____(initial)

☐ I verify that neither I nor anyone in my household has traveled outside of _____ in the past 14 days._____(initial)

☐ I understand that the CDC recommends social distancing of at least 6 feet, and this is not possible with the service I am receiving today._____(initial)

By signing below I knowingly and willingly consent to release any and all liability for the unintentional exposure or harm due to COVID-19.

_____	_____	_____
Name Printed	Signature	Date

Cancellation Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone. 512-648-0042 or SBSkinBody@gmail.com

ANY APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE WILL RESULT IN A CHARGE EQUAL TO THE AMOUNT OF THE RESERVED SERVICE. . ALL "NO SHOWS" WILL BE CHARGED 100% OF THE RESERVED SERVICE AMOUNT.

We recognize the time of our clients and therapist is valuable and have implemented this policy for this reason. When you miss an appointment with us, we not only lose your business but also the potential business of other clients who could have scheduled an appointment for the same time.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

I have read and understood the cancellation policy and agree to abide by the above conditions.

Name Printed	Signature	Date