Client Intake Form

Today's Date: __/__/__

Name: ___________________________Female/Male

Birthday: __/__/_____ Occupation: ______________

Address: __________________City: ________ Province: ___ Postal Code: _______

Cell Phone: ___________ Home Phone: ____________ Work Phone: ____________

E-Mail: _____________________ Emergency Contact: _____________________

How May We Contact You for Appt. Confirmations? ___________________

How did you hear about us? ________________________ (Name of person/ source)

To better serve you, please check the issues you'd like to discuss:

Wrinkles

- Forehead lines
- Frown lines
- Crow's feet
- Bunny lines
- Lip lines
- Other

Acne

- Cystic Acne
- Nodular Acne
- Blackheads
- Whiteheads
- Acne scars

Volume Loss

- Dark under eye circles
- Fallen Cheeks
- Hollow temples
- Jowls
- Sagging facial skin
- Gaunt face
- Other

Other

- Migraines
- TMJ
- Excess sweating (Hyperhidrosis)
- defined chin/jawline/nose
- Facial Scars
- Lips (Small, wrinkled or ill defined)
- Gummy Smile
- Unwanted Hair
- Dry Skin
- Oily Skin
- Combination Skin
- Sensitive Skin
- Congested Skin
- Rosacea
- Moles
- Puffiness
- Elasticity Loss (loose skin)
- Aging
- Large Pores
- Broken Capillaries
- Sun Damage
- Freckles
- Melasma
- Dark Spots/Patches
- Scaling/Flaking
- Razor Bumps
- Ingrown Hairs
- Stretch Marks
- Unwanted Tattoo

What are Your Top 3 Concerns? 1) __________ 2) _________ 3) __________

What Treatments Have You Had in the Past? (please check all that apply)

- Botox/Dysport
- Chemical Peels
- Dermal Fillers: Juvederm, Perlane, Restylane, Emervel, other

- Eyelash enhancements
- Dermaplaning
- Medical Facials
- Microdermabrasion
- Microneedling
- Fractional Resurfacing Laser
- Infrared (IR) Skin Tightening Laser
- Intense Pulsed Light (IPL)
- Radio Frequency (RF)Fat Reduction Laser
- Other:____
  ____

Have you previously seen an Aesthetician?________ If yes, for how long? ______________

MEDICAL HISTORY

Do you have any of the following?

- Cold Sores
- Immune Disorder
- Migraines
- Diabetes
- High Blood Pressure
- Lupus
- Epilepsy
- Hormone Imbalance
- Hepatitis
- Heart Disease
- Cancer
- Metal Implants
- Pacemaker
- Herpes
- Psoriasis/Vitiligo
- Myasthenia Gravis
- Currently Pregnant
- Breastfeeding

If yes, Please Explain: ____

Have you ever had a reaction to any of the following?

- Dairy
- Cosmetics
- Fragrance
- Aspirin

- Latex
- Lidocaine
- Hydrocortisone
- Gluten
- Hydroquinone or skin bleaching agents
- Aloe Vera
- Other: ____

Please check if you are currently using the following:

- Acne topical treatments (Retin A, Renova, Differin, Adapalene, Retinol, Tazorac)
- Aspirin, Ibuprofen, Advil, Aleve
- Coumadin (warfarin)
- Accutane
- Antibiotics
- Birth control Pills/Hormone Replacement Therapy

SKIN CARE

Do you have any special skin problems pertaining to your face and body? __Yes __ No

If yes, please specify ____

For unwanted hair do you? Wax __Tweeze __Laser __Electrolysis__

What skin care products are you currently using?

- Soap
- Cleanser
- Toner
- Moisturizer
- Masque
- Exfoliator
- Eye Products
- Sunscreen
- Shaving Products
- Prescription Skin

Care Product

- Acne products
- Foundation
- Skin Lighteners
- Retinols
- Others

What brand name(s) to do you use? ______________________________

What SPF sunscreen do you use on your face? _________ body? _________

STATEMENT

If I experience any pain or discomfort during the session, I will immediately inform the aesthetician so that the products and/or technique may be adjusted to my level of comfort.

I understand that aestheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

I affirm that I have stated all my known medical conditions, and answered all questions honestly.

I agree to keep the aesthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the aesthetician's part should I fail to do so.

I also understand that the aesthetician reserves the right to refuse treatments on anyone whom he/she deems to have a condition for which treatments are contraindicated.

Client Signature ________________________________Date ______________

Please fill out as completely as you are able. All information will be held in strict confidence.

Please keep us updated with any changes in your health. Thank you