FACIAL TREATMENT
client intake form

CLIENT INFORMATION:

Name: Date:

Date of birth: Age:

Address:

City: Postal Code:

Email Address:

Phone: Emergency Contact:

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- ○ Acne
- ○ Autoimmune disorders
- ○ Cold sores or fever blisters
- ○ COPD
- ○ Cancer
- ○ Diabetes
- ○ Dermatitis
- ○ Eczema
- ○ Epilepsy
- ○ Glaucoma
- ○ Heart disease
- ○ High Blood Pressure
- ○ Hepatitis B or C
- ○ Herpes simplex
- ○ Hemophilia
- ○ HIV/AIDS
- ○ Keloids or hypertrophic scars
- ○ Migraines
- ○ Psoriasis
- ○ Rosacea
- ○ Skin infections
- ○ Seborrheic
- ○ Tinea
- ○ Urticaria (Hives)
- ○ Warts
- ○ Other _____

CLIENT SKIN CONCERNS

What are your main skin concerns?

- ○ Acne, Breakouts
- ○ Blackheads
- ○ Dry skin
- ○ Oily skin
- ○ Dull skin
- ○ Dehydrated skin
- ○ Fine lines and wrinkles
- ○ Dark circles under the eyes
- ○ Hyperpigmentation (dark spots)
- ○ Sun damage
- ○ Age spots
- ○ Melasma
- ○ Scars
- ○ Keratosis pilaris
- ○ Ingrown hairs
- ○ Razor burn
- ○ Rosacea
- ○ Eczema
- ○ Enlarged pores
- ○ Skin redness
- ○ Under-eye puffiness
- ○ Uneven skin tone
- ○ Uneven skin texture
- ○ Premature aging
- ○ Psoriasis
- ○ Whiteheads
- ○ Excessive facial hair

YOUR SKIN TYPE

What is your skin type?

- ○ Normal skin
- ○ Dry skin
- ○ Oily skin
- ○ Combination skin
- ○ Sensitive skin
- ○ Acne-prone skin
- ○ Aging skin
- ○ Dehydrated skin
- ○ Rosacea-prone skin
- ○ Sun-damaged skin
- ○ Hyper pigmented skin
- ○ Psoriasis-prone skin

YOUR SKINCARE ROUTINE

What is your skin routine?

- ○ Foam Cleanser
- ○ Gel Cleanser
- ○ Makeup Remover
- ○ Toner
- ○ Moisturiser
- ○ Eye Cream
- ○ Sunscreen
- ○ Face mask
- ○ Exfoliant
- ○ Serum
- ○ Spot Treatment
- ○ Facial Oil

SKIN CARE HISTORY

Have you ever had an allergic reaction to any of the following?

- ○ Cosmetics
- ○ Medication
- ○ Food
- ○ Animals
- ○ Sunscreen
- ○ Iodine
- ○ Pollen
- ○ Skin Products
- ○ Essential Oils
- ○ Nuts
- ○ Alpha Hydroxy Acids
- ○ Fragrance
- ○ Shellfish
- ○ Latex
- ○ Aspirin
- ○ Other

If yes to any of the above, please explain

.....

Are you taking any medications, vitamins, including over-the-counter or prescription drugs?

○ Yes ○ No .....

Have you experienced Botox, Restylane or Collagen injections?

○ Yes ○ No .....

Within the last nine months, have you undergone any surgery or plastic surgery?

○ Yes ○ No .....

How much time do you spend in the sun, and what is your level of sun protection?

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What are your expectations and goals for the treatment?

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Are you currently using any products that contain the following ingredients?

- ○ Glycolic acid
- ○ Acetic acid
- ○ Any exfoliating scrub
- ○ Any hydroxy acid product
- ○ Vitamin A derivatives (i.e. retinol)
- ○ Renova

Have you recently received any of the following treatment?

- ○ Microdermabrasion
- ○ Chemical Peel
- ○ Lash Tint
- ○ Brow Tint
- ○ Micro Needling
- ○ Facial Waxing

YOUR HEALTH

Have you used or been prescribed any medications (topical or oral) for acne / acne control?

○ Yes ○ No .....

Do you drink more than 4 caffeinated beverages a day? (tea, coffee, soda, energy drinks)

○ Yes ○ No .....

Have you ever experienced claustrophobia?

○ Yes ○ No .....

FEMALE CLIENTS

Are you taking birth control?

○ Yes ○ No .....

Are you pregnant or trying to become pregnant?

○ Yes ○ No .....

Are you undergoing any hormone replacement therapy?

○ Yes ○ No .....

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this skin care professional from liability and assume full responsibility thereof.

Client Printed Name	Clients Signature	Date
Estheticain Name	Esthetician Signature	Date