

**Client Intake Form - Facial**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_**

**Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_**

**Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been under the care of a Physician, Dermatologist, or other medical professional within the last year? ( ) No ( ) Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any of these health conditions in the past or present?**

**(Please check all that apply and provide additional information in the space provided)**

**0 Cancer 0 Arthritis 0 Immune disorders**

**0 Hormone imbalance 0 Asthma 0 HIV/AIDS**

**0 Systemic disease 0 Eczema 0 Lupus**

**0 High blood pressure 0 Epilepsy 0 Metal bone pins/plates**

**0 Spinal injury 0 Seizure disorder 0 Phlebitis/blood clots**

**0 Thyroid condition 0 Headaches (chronic) 0Abnormal blood clotting**

**0 Hysterectomy 0 Fever/blisters 0 Psychological treatment**

**0 Diabetes 0 Hepatitis 0 Insomnia**

**0 Heart problems 0 Herpes 0 Keloid scarring**

**0 Varicose veins 0 Frequent cold sores 0 Skin disease/ lesions**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List any medications/vitamins you take regularly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, Salicylic Acid, or Retinol? ( ) No ( ) Yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you sunbathe or use a tanning bed? ( ) No ( ) Yes**

**Do you use sunscreen ( ) No ( ) Yes**

**Have you ever had an adverse reaction after using any skin care product ( ) No ( ) Yes**

**0 Rash 0 Irritation 0 Peeling 0 Sun Sensitivity 0 Breakout**

**(Over)**

**Please list any allergies you have \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you pregnant or trying to become pregnant ( ) No ( ) Yes Nursing? ( ) No ( ) Yes**

**Which of the following have you had in the past?**

**0 Botox 0 Collagen (fillers)**

**0 Laser hair removal 0 Permanent make-up**

**0 Microdermabrasion 0 Chemical peels**

**Which of the following best describes your skin type?**

**0 Very oily skin/large pores 0 Dry skin**

**0 Combination skin 0 Sensitive skin**

**0 Oily in T-zone, dry to normal cheeks 0 Oily skin**

**Please mark your skin concerns:**

**0 Unwanted hair Area\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 0 Pigmentation**

**0 Acne 0 Fine lines**

**0 Discoloration 0 Brown spots**

**0 Rosacea 0 Wrinkles**

**0 Loss of skin tone 0 Broken capillaries/veins**

**0 Dryness 0 Large pore size**

**0 Sun damage**

**Other concerns? Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What type of pressure do you prefer for your massage on legs/feet/shoulders/arms?**

**0 Light 0 Medium 0 Firm**

**What would you like to be the focus in your facial today? Please rate each individual topic (1 is the least important and 5 is the most important)**

**\_\_\_\_\_ Relaxation \_\_\_\_\_ Hand/shoulder/arm massage**

**\_\_\_\_\_ Facial massage \_\_\_\_\_ Scalp massage**

**\_\_\_\_\_ Extractions \_\_\_\_\_ Aromatherapy**

**\_\_\_\_\_ Education on products/homecare \_\_\_\_\_ Foot/leg massage**

**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. I am aware that it is my responsibility the inform the esthetician/ skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.**

**Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**