FLOURISH THERAPIES
massage & skincare

SKIN THERAPY CLIENT INTAKE & CONSENT FORM

Name _____ Date of birth: _____

Address _____ City, State, Zip _____

Preferred Phone Number _____ Email _____

Occupation _____ Emergency Contact Name/Phone _____

How did you hear about Flourish Therapies? _____

Health Historv

Are you currently under a physician's care? _____ Yes _____ No **If yes, please explain** _____

_____

Please list current medications & vitamin/supplements: _____

_____

Describe your skin: (check all that apply)

__ Normal __ Combination __ Oily __ Dry/Flaky __ Uneven/blotchy __ Rosacea ___ Acne

__ Broken Capillaries/Telangiectasia ___ Scarring ___ Saggy ___ Redness/Sensitivity

___ Wrinkles/Fine lines ___ Hypo-pigmented ___ Hyper-pigmented ___ Large Pores

___ Breakouts; How Often?_____ ___ Black Heads ___Sun Damage/Spots

Have you had a facial treatment before? If yes, what type and how often? _____

I Consume: Coffee/Tea: _____ amt. per day Soda: _____. per day Alcohol: _____amt. per day

Water: _____amt. per day Smoke/Tobacco: _____amt. per day Dairy: _____amt. per day

On average, how many hours of sleep do you get each night? _____

On a scale of 1 – 10 what is your current stress level? _____

Medical History - Please check all that apply:

___ Cancer ___ High Blood Pressure ___ Spinal Injury ___ Thyroid condition ___ Diabetes ___ Heart Problem

___ Hormonal Issues/Disorder ___ Asthma ___ Eczema ___ Epilepsy ___ HIV/AIDS ___ Lupus

___ Metal bone/pins or plates ___ Keloid Scarring ___ Phlebitis/blood clots ____ Pacemaker

___ Poor circulation ___ Skin disease / skin lesion ___ Any active infection

Are you currently pregnant/lactating or trying to become pregnant? _____ Yes _____ No

Do you wear contact lenses? ___ Yes ____ No **Have you ever experienced claustrophobia?** ___ Yes ___ No

Do you get cold sores/fever blisters? If yes, do you take medication to treat them?_____

Please list any allergies (food, product, medication): _____

_____

Are you using any of the following? ___ Accutane ___ Retinol ___ Retin A ___ Glycolic ___ AHA/BHA

___ Benzoyl Peroxide ___Salicylic Acid ___ Differin ___ Antibiotics ___ Valtrex/Zovirx

Have you ever had a reaction to a product or ingredient? If yes, please describe. _____

_____

Do you: ___ Burn ___ Usually Burn ___ Burn then tan ___ Usually tan ___ Always tan

Do you use a tanning bed? __ Yes __ No

Do you get facial waxing, electrolysis, mirco/dermabrasion, laser, chem. peels or use depilatories? __ Yes __ No

Have you had any collagen/fillers, botox injections, or cosmetic surgery? If yes, please list:_____

_____

I use these products on my skin: (Check all that apply)

___ Scrub ___ Eye Cream ___ Toner ___ Cleanser ___ Makeup ___ Mask ___ Bar Soap

___ Daily Moisturizer ___Night Moisturizer ___ Special Product/Medication ___ Makeup Remover

___ Sunscreen; SPF & Frequency of application? _____

What is your goal for this facial treatment?

_____

_____

_____

POLICIES AND PROCEDURES
It is understood that any inappropriate suggestive remarks or advances will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I agree to give a 24-hour notice for a scheduled session I cannot keep. I agree to be charged 50% of the service that I do not give a 24-hour notice to cancel or reschedule. I agree that if I am late for a service I have scheduled, the esthetician may subtract time from my treatment as to not penalize the client that may be following my scheduled service.

CLIENT AGREEMENT
If I experience any pain or discomfort during this session, I will immediately inform the esthetician so that the session may be adjusted to my level of comfort. I further understand that esthetics should not be considered as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that licensed estheticians are not qualified to diagnose, prescribe, or treat any physical or mental illness, and nothing that is said in the course of the session given should be construed as such. Because esthetics should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the Esthetician at Flourish Therapies updated as to any changes in my medical profile and understand that there shall be no liability on Flourish Therapies and the esthetician's part should I fail to do so.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if under 18 years or younger): _____ Date:_____