



## CLIENT INTAKE FORM

Please fill out the following pages.

Date: \_\_\_\_\_ Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Sex: \_\_\_\_\_ Phone #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Email: \_\_\_\_\_

(We will only send out important news and updates)

Do you have a preferred name? (Optional): \_\_\_\_\_ How did you hear about Studio Skyn? \_\_\_\_\_

### Emergency Contact Information

Name: \_\_\_\_\_ Phone#: \_\_\_\_\_

Relation: \_\_\_\_\_

### Important Information

All information is kept confidential.

Conditions you experience in the average week: (Select all that apply)

- |  |  |                                       |  |   |
|--|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anxiety       | <input type="checkbox"/> Confusion       | <input type="checkbox"/> Dehydration  | <input type="checkbox"/> Depression    | <input type="checkbox"/> Fatigue                |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Headaches       | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Insomnia      | <input type="checkbox"/> Muscle Cramps          |
| <input type="checkbox"/> O.C.D.        | <input type="checkbox"/> Persistent Pain | <input type="checkbox"/> Stress       | <input type="checkbox"/> All The Above | <input type="checkbox"/> Prefer Not to Disclose |

What type of skin **do you think** you have?

- |                                 |                               |                              |                                      |   |
|---------------------------------|-------------------------------|------------------------------|--------------------------------------|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Oily | <input type="checkbox"/> Dry | <input type="checkbox"/> Combination | <input type="checkbox"/> Unsure / Unknown |
|---------------------------------|-------------------------------|------------------------------|--------------------------------------|---|

Have you ever had an allergic reaction to any of the following: (Select all that apply)

- |  |   |   |   |   |
|--|---|---|---|---|
| <input type="checkbox"/> A.H.A.s / B.H.A.s | <input type="checkbox"/> Animals (describe below) | <input type="checkbox"/> Cosmetics              | <input type="checkbox"/> Drugs / Medication | <input type="checkbox"/> Foods (describe below) |
| <input type="checkbox"/> Fragrance         | <input type="checkbox"/> Iodine                   | <input type="checkbox"/> Latex                  | <input type="checkbox"/> Nuts / Tree Nuts   | <input type="checkbox"/> Pollen                 |
| <input type="checkbox"/> Shellfish         | <input type="checkbox"/> Sunscreen / SPF          | <input type="checkbox"/> Other Allergies: _____ |   |   |

What areas of concern do you have regarding your skin: (Select all that apply)

- ☐ Acne/Breakouts    ☐ Black/Whiteheads    ☐ Broken Capillaries    ☐ Dehydrated/Dry    ☐ Dull Appearance  
☐ Excessive Oil/Shine    ☐ Redness/Ruddiness    ☐ Rosacea    ☐ Sun Damage    ☐ Liver/Brown Spots  
☐ Uneven Skin Tone    ☐ Wrinkles/Fine Lines    ☐ Other: \_\_\_\_\_

Do you plan on attending any special events in the next 7-10 days? ☐ Yes ☐ No

Have you been under the care of a dermatologist within the past year? ☐ Yes ☐ No

- If Yes, please explain what for: \_\_\_\_\_
- If Yes, who is your dermatologist? \_\_\_\_\_

Do you currently or have you used in the last 3 months:

- ☐ Avage    ☐ Differin    ☐ Renova    ☐ Restylane    ☐ Retin-A    ☐ Tazorac    ☐ Tretinoin    ☐ Retinol/ Vitamin A

- If Yes, Please describe what for, how often, and % you use: \_\_\_\_\_

Have you received any of the following in the last 3 months:

- ☐ Botox Injections    ☐ Collagen Injections    ☐ Restylane Injections    ☐ Other Filler Injections

- If Yes, Please describe when and where on your face/body: \_\_\_\_\_

### Health Related

All information is kept confidential

☐ Yes ☐ No - Are you pregnant or planning to become pregnant?

☐ Yes ☐ No - Are you Nursing?

☐ Yes ☐ No - Are you currently taking any antibiotics? (May increase sensitivity.)

☐ Yes ☐ No - Are you currently taking any blood thinners? (If yes, your service **may** have to be rescheduled.)

☐ Yes ☐ No - Do you have any **metal** implants/pins/plates or **medical** implants? (Including dental, and full body)

- If yes, where is it located and what type of implant is it? \_\_\_\_\_

☐ Yes ☐ No - Do you smoke cigarettes, e-pens, or vape regularly?

☐ Yes ☐ No - Do you work out or participate in vigorous aerobic activities/sports? How often: \_\_\_\_\_ X a Week

☐ Yes ☐ No - Have you had: ☐ Cold Sores    ☐ Herpes    ☐ Hives    ☐ Keloids outbreak in the past 30 days?

- If Yes, when and where was your last outbreak: \_\_\_\_\_

☐ Yes ☐ No - Do you wear Contact Lenses?

☐ Yes ☐ No - Do you wear sunscreen (SPF) on a regular basis?

☐ Yes ☐ No - Have you visited a tanning booth within the last week? (If yes, your service **may** have to be rescheduled.)

☐ Yes ☐ No - Have you received a spray tan within the last week? If Yes, when: \_\_\_\_\_

☐ Yes ☐ No - Have you been sunburned in the past two weeks?

**Skin Care Related:**

☐ Yes ☐ No - Are you currently using products containing Glycolic Acid, other Alpha Hydroxy Acids (AHAs) or Beta Hydroxy Acids (BHAs)?

• If Yes, how long have you been using the products and how has your skin reacted to it? \_\_\_\_\_

☐ Yes ☐ No - Are you currently using Accutane? (Acne Medication) If Yes, How long? \_\_\_\_\_

☐ Yes ☐ No - Have you ever used Hydroquinone? (Skin Lightner) If Yes, how long ago? \_\_\_\_\_

☐ Yes ☐ No - Do you currently use wax, electrolysis, or depilatories on your face?

• If yes, when and what was your last treatment? \_\_\_\_\_

Have you **ever** had any of the following services or treatments?

Microdermabrasion ☐ Yes ☐ No When: \_\_\_\_\_ Microneedling ☐ Yes ☐ No When: \_\_\_\_\_

Microblading ☐ Yes ☐ No When: \_\_\_\_\_ Chemical Peel ☐ Yes ☐ No When: \_\_\_\_\_

Laser Resurfacing ☐ Yes ☐ No When: \_\_\_\_\_ Facial Surgery ☐ Yes ☐ No When: \_\_\_\_\_

Collagen or Botox ☐ Yes ☐ No When: \_\_\_\_\_

Dermaplaning ☐ Yes ☐ No When: \_\_\_\_\_

Permanent Make Up ☐ Yes ☐ No When: \_\_\_\_\_

To help us determine a facial regimen suitable for you, please describe your skin-type: (Check all that apply)

☐ Thick ☐ Thin ☐ Saggy ☐ Firm ☐ Sensitive ☐ Resilient ☐ Normal

☐ Dry ☐ Rosacea ☐ Eczema ☐ Oily ☐ Acne ☐ Prone to breakouts

☐ Combination ☐ Large Pores ☐ Small Pores ☐ Freckled ☐ Sun Damaged ☐ Acne Scarred ☐ Unevenness

☐ Melasma ☐ Psoriasis ☐ Wrinkled ☐ Mature ☐ Broken Capillaries ☐ Milia

☐ Congested ☐ T-Zone Congestion ☐ Hyper-Pigmentation ☐ Hypo-Pigmentation

What is your skin-tone: (Check all that apply)

☐ Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Olive

☐ Light Brown ☐ Med. Brown ☐ Dark Brown ☐ Black ☐ Other: \_\_\_\_\_

What is your natural eye color:

☐ Blue ☐ Green ☐ Hazel ☐ Grey ☐ Light Brown ☐ Med. Brown ☐ Dark Brown

What is your natural hair color: (not the color it is currently dyed)

☐ White ☐ Black ☐ Blond ☐ Red ☐ Grey/Silver ☐ Salt & Pepper

☐ Light Brown ☐ Med. Brown ☐ Dark Brown ☐ Other: \_\_\_\_\_ (Natural colors only please)

During facial services we include extractions, décolleté, and shoulder to hand hydration therapy.

If you **DO NOT** want any of these services, please check the following: (Men's facials include pectorals/chest)

☐ Extractions ☐ Decollete Hydration Therapy ☐ Arm / Hand Hydration Therapy **(Men Only)** ☐ Chest Hydration Therapy

### Questionnaire:

What improvements would you like to see in your skin? \_\_\_\_\_

What type of facial treatment did you last have? \_\_\_\_\_

What did you enjoy most about the treatment? \_\_\_\_\_

What did you least like about the treatment? \_\_\_\_\_

## CONSENT AGREEMENT

I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed of and understand the contraindications to the requested treatments and 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 liabilities toward my esthetician and Studio Skyn, LLC. for any injury or damage incurred due to any misrepresentation of my health history.

I understand that although complications are very rare, sometimes they may occur, and that prompt treatment is necessary. In the event of any complications, I will immediately contact the technician who performed the treatment.

I understand that Studio Skyn, LLC. does not offer massage as a form of therapy, nor is Studio Skyn, LLC a licensed massage therapy spa. Hydration Therapy included in services assists in blood circulation and relaxation and is not intended to be therapeutic in nature. Clients may refuse this complementary service by notifying the esthetician before services are rendered.

I understand that certain skin conditions are recommended to be seen by a Licensed Dermatologist before skin treatments may be performed. I understand that estheticians are not licensed to diagnose or treat serious skin conditions and will discuss options with me at the time of my service if necessary.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Studio Skyn, LLC. updated as to any changes in my medical profile and understand that there shall be no liability of the service provider should I fail to do so. My questions regarding the treatment have been answered satisfactorily.

I understand these treatments are cosmetic treatments and that no medical claims are expressed or implied. I understand that to achieve maximum results, I may need several treatments. I understand the treatment and accept any risks. I hereby release Studio Skyn, LLC and its staff from all liabilities associated with the above indicated treatment. I agree that this consent supersedes any previous verbal or written disclosures.

This consent is valid for all my future facial treatments until February 29<sup>th</sup>, 2026. Each visit I will sign a Returning Treatment Consent when needed, in which I will inform Studio Skyn, LLC any updates to my most recent skin and related health history.

\_\_\_\_\_  
Signature of Client (Or Guardian)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Esthetician

Ryan DuPree      FB9771808  
\_\_\_\_\_  
Print Name & License Number

\_\_\_\_\_  
Date