CLIENT INTAKE FORM

Date: _____ Name: _____ D.O.B: _____

Sex: _____ Phone #: _____ Occupation: _____

Address: _____

Email: _____
(We will only send out important news and updates)

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)

☐ Anxiety ☐ Confusion ☐ Dehydration ☐ Depression ☐ Fatigue
☐ Forgetfulness ☐ Headaches ☐ Inflammation ☐ Insomnia ☐ Muscle Cramps
☐ O.C.D. ☐ Persistent Pain ☐ Stress

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Not Sure / Unknown

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: _____

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

☐ A.H.A.s or B.H.A.s ☐ Animals (describe below) ☐ Cosmetics ☐ Drugs/Medication ☐ Food (describe below)
☐ Fragrance ☐ Iodine ☐ Latex ☐ Nuts/Tree Nuts ☐ Pollen
☐ Shellfish ☐ Sunscreen/SPF ☐ Other Allergies: _____

_____

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:

☐ A.H.A.s or B.H.A.s ☐ Avage ☐ Differin ☐ Renova ☐ Restylane ☐ Retin-A
☐ Tazorac ☐ Retinol/Vitamin A Derivatives

- If Yes, Please describe what for and how often: _____

_____

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 body: _____

_____

BY SIGNING BELOW, YOU AGREE TO THE FOLLOWING:

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 damages incurred due to any misrepresentation of my health history.

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 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 doctor/clinician 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. Massages offered are included in services to assist in blood circulation and relaxation are not intended to be therapeutic in nature. Clients may refuse massages 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.

_____	_____	_____
Signature of Client (Or Guardian)	Print Name (Relation if necessary)	Date
_____	Ryan DuPree FB9771808	_____
Signature of Esthetician	Print Name	Date