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

_____

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 ☐ Retinol/ Vitamin A

- 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: _____

_____

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:	→	→	→ Within the last 30 days?
Microdermabrasion	☐ Yes ☐ No	When: _____	☐ Yes
Chemical Peel	☐ Yes ☐ No	When: _____	☐ Yes
Laser Resurfacing	☐ Yes ☐ No	When: _____	☐ Yes
Collagen or Botox	☐ Yes ☐ No	When: _____	☐ Yes
Facial Surgery	☐ Yes ☐ No	When: _____	☐ Yes
Permanent Make Up	☐ Yes ☐ No	When: _____	☐ Yes

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 ☐ Decollate 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 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. 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 of my future facial treatments until February 29th, 2024. Each visit I will provide and sign a Returning Treatment Consent when needed, which will update my file to my most recent health history.

_____	_____	_____
Signature of Client (Or Guardian)	Print Name	Date
_____	Ryan DuPree FB9771808	_____
Signature of Esthetician	Print Name & License Number	Date