Facial Services

CLIENT INTAKE FORM

Name _____ Date _____

Occupation _____ Birthday _____ Female Male NB

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Emergency Contact _____ Emergency Contact Phone # _____

How did you learn about us? _____

Would you like to be added to our email list for new and exciting offers? Yes No

MEDICAL HISTORY

Do you have any of the following conditions? If yes, please select them:

- Arthritis/ joint disorder
- Artificial joint
- Atherosclerosis
- Blood disorder
- Back/ neck problems
- Cancer
- Carpal tunnel syndrome
- Circulatory disorder
- Contagious skin condition
- Decreased sensation
- Deep vein thrombosis
- Diabetes
- Easy bruising
- Eczema
- Epilepsy
- Fever blisters
- Fibromyalgia
- Headaches/ migraines
- Heart condition
- High/ low blood pressure
- Immune disorders
- Keloid scarring
- Open sores or wounds
- Osteoporosis
- Phlebitis
- Pregnant
- Recent accident/ injury
- Recent fracture
- Seborrhea
- Seizure disorder
- Skin disease/ lesions
- Sprains/ strains
- Swollen glands
- Tennis elbow
- TMJ
- Varicose veins

Any other illness/ condition: _____

Any recent surgery, including plastic surgery? _____

Are you currently taking any medications? _____

Are you currently being treated by a medical professinal? _____

Facial Services

CLIENT INTAKE FORM

SKIN HISTORY:

Have you had a facial before? ☐ Yes ☐ No

Do you have any allergies to oils, lotions, or ointments? ☐ Yes ☐ No

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

If yes, please explain: _____

Do you currently or have used in the past 3 months Retinal, AHA's, or BHA's? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever used acne medication? ☐ Yes ☐ No

If yes, please explain when and what drug: _____

Have you received Botox or collagen injections in the last 3 months? ☐ Yes ☐ No

If yes, please explain when and what drug: _____

What type of skin do you have? ☐ Combo ☐ Dry ☐ Oily ☐ Normal ☐ Unsure

SKIN CONCERNS: *Do you have any of the following conditions? If yes, please select them:*

- ☐ Acne
- ☐ Blackheads
- ☐ Eczema
- ☐ Fine Lines/ Wrinkles
- ☐ Oily Skin
- ☐ Psoriasis
- ☐ Redness
- ☐ Rosacea
- ☐ Sensitivity
- ☐ Sun damage
- ☐ Hyperpigmentation
- ☐ Other

By signing below, I acknowledge that Elevated Wellness Massage and Spa and its esthetician are not liable for any injury, reaction, or damage that may occur as a result of the facial treatment(s) received. I understand that all services are provided based on the information I have disclosed and performed with appropriate professional care.

Client Name (Printed) _____ Date: _____

Client Name (Signature) _____

☐ Initial this box that you positively identify as the name printed & sign