Skin Consult Intake Form

All information is confidential

Welcome to **The Melanin Studio**. We are committed to providing you with unparalleled services and products. Please complete the following form as thoroughly as possible to help us achieve this goal. Thank you for choosing The Melanin Studio! It is our pleasure to serve you.

Name (please print)_____
DOB_____
Today's Date_____
Address_____ City _____ Postal Code _____
Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____
Email_____ May we add you to our email list? ___Yes___No thank you
Whom may we thank for your referral? _____

The following information is essential to optimize the results of your service:

1) Which concerns apply to your skin? Please check all that apply:

____ Uneven Skin Tone ____Dark Spots (Hyperpigmentation) _
____Sensitivity /Redness ____Fine Lines/Anti Aging
____Skin Laxity ____Dryness
____Acne ____Clogged Pores
____Excessive Oiliness ____Scarring
____Unwanted Hair
____Please List Other Concerns: _____

2) Please check the skincare products you currently use and their brand names:

____Cleanser _____
____Toner _____
____ Exfoliant_____
____Serum _____
____Moisturizer/Day _____
____Moisturizer/Night_____
____Eye Cream _____
____SPF _____
____Other _____

3) Please check the prescription or herbal medications you are currently using:

____ Accutane
____ Differin
____ Retin-A, Renova
____ Tazorac
____ Antibiotics (Oral or Topical)
____ Vitamins
____ Minerals
____ Herbs
____ Apple cider vinegar
____ Other Please List _____

4) Are you allergic to any cosmetic ingredient, medication or food? Please List _____

5) In the past 30 days, please list all professional facial or dermatology services you have received (i.e. Chemical Peel, Microdermabrasion, Laser, Botox ®, other cosmetic injectables, lightening agents etc.):
_____

6) Please take a moment to carefully read the following list of conditions and check any that have affected your health either recently or in the past:

____ Wearing Contact Lenses
____ Pregnant, Which Trimester?_____
____ Trying to get pregnant
____ Herpes Virus (i.e. cold sore, fever blister)
____ Hormonal Therapy/ Imbalance
____ Skin Cancer Where/When:
____ High or Low Blood Pressure
____ Thyroid (over or under active)
____ Heart Condition / Pacemaker
____ Diabetes
____ Epilepsy or Seizures
____ Metal implants. Location: _____
____ Tension Headaches / Migraines
____ Surgeries What / When?_____
____ High level of Stress
____ Sinus Infection
____ Varicose Veins
____ Braces
____ Dental fillings
____ Smoker
____ Contagious Conditions_____

7) Are there other Spa or Medical Spa services that you would you like more information about?
_____

8) What skin care regimen are you currently using?
Morning
_____
_____

Evening
_____
_____

9) Have you ever had a professional body treatment before ___Yes ___No
10) Would you like to share your picture? ___Yes ___No

All of the above information is true and accurate to the best of my knowledge. I take full responsibility for alerting my Esthetician to any physical or mental condition which would affect my service or results.
I understand my treatment is therapeutic in nature and will alert my Esthetician to any discomfort.
(Initials:_____)

I confirm that to the best of my knowledge, the answers I have given are correct and I have not withheld any information that may be relevant to my treatment. I also agree to the terms that once treatment has started I am not entitled to a refund.

Failure to complete packages deal will result in SINGLE PRICING.

Signature_____ Date_____