CLIENT INTAKE FORM - FACIAL

Name_____ Date of birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (h) _____ (c) _____ (w) _____

Referred by: _____ Phone: _____ Emerg. Contact _____ Phone: _____

Occupation: _____ Age: _____ Male Female

Physician: _____ Health Insurance Carrier: _____

Please take a moment to answer the following questions.

1. Is this your first facial? Yes No
2. What is your main concern with your skin? _____

   _____
3. Are you presently under a physician's care for any current skin condition or other problem? Yes No
4. Are you pregnant? Yes No
5. Are you taking birth control pills? Yes No

   If "Yes", what type? _____
6. Are you presently using (or used in the past) Azlex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alpha Hydroxy Acids? Yes No

   If "Yes", when and for how long? _____

   _____
7. Are you now using or have you ever used Accutane? Yes No
8. Are you presently taking any medications? Yes No

   If so, please list _____

   _____
9. Do you wear contact lenses? Yes No
10. Do you smoke? Yes No
11. Do you have any allergies to cosmetics, food or drugs? Yes No

    If so, please list _____

    _____
12. Have you had skin cancer? Yes No

    If so, what? _____
13. Do you often experience stress? Yes No
14. What skin car products do you use presently? _____

    _____

Please check if you are affected by or have any of the following:

Asthma	Fever blisters	Hysterectomy	Sinus Problems	Metal bone,
Cardiac Problems	Headaches-chronic	Skin Disease	Immune Disorders	pins, or plates
Depression	Anxiety	Hepatitis	Lupus	
Herpes	Epilepsy	High Blood Pressure	Pace Maker	
			Eczema	

Please explain above problems or list any other significant issues. _____

_____

I understand that the services offered are not a substitute for medical care; and any information provided by the therapist, is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Cancellations:
We request a minimum of 24 hours notice for cancellations of any scheduled appointments or a minimum of 48 hours for a group cancellation to avoid any unnecessary changes. 50% of your scheduled services will be required without a 24 hour notice, and full price of your scheduled appointment will be required if no notice has been given. Late arrivals may result in reduced or cancelled service.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By signature below, I hereby authorize _____ to Administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.
Signature of Parent or Guardian:

_____ Date _____
