

# SCOTTSDALE SKIN RENEWAL

## INTAKE FORM

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_

Emergency Contact Relationship \_\_\_\_\_ Phone \_\_\_\_\_

1. How did you hear about us? \_\_\_\_\_ Advertisement \_\_\_\_ Family/Friend \_\_\_\_ Internet Search  
\_\_\_\_ Website \_\_\_\_ Other Source: \_\_\_\_\_

2. Have you been under the care of any physician, dermatologist, or other medial professional within the past year? If so, please explain.  
\_\_\_\_\_

3. List any medications, supplements, or herbal/homeopathic remedies you currently take.  
\_\_\_\_\_

4. Are you using topical medication or exfoliating acids such as salicylic or glycolic? YES NO  
If yes, please explain: \_\_\_\_\_

5. Do you have any known allergies (seasonal, drug, food, etc.)? \_\_\_\_\_

6. What are you currently using to cleanse and moisturize your face? \_\_\_\_\_  
\_\_\_\_\_

7. Do you currently experience any reaction (swelling, redness, itching) after a bug bite?  
\_\_\_\_\_

8. How would you rate the overall quality of your skin? POOR FAIR GOOD VERY GOOD EXCELLENT

9. What improvements would you like to see to your skin? \_\_\_\_\_

10. When you go out in the sun, do you (circle one):  
ALWAYS BURN USUALLY BURN SOMETIMES BURN RARELY BURN NEVER BURN

11. Are you planning a vacation in the sun within the next 30 days? YES NO

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12. When were you last exposed to the sun or a tanning booth? \_\_\_\_\_

13. Have you ever been treated for any of the following (please circle all that apply)?

Acne Anxiety Skin Disease High Blood Pressure Frequent Cold Sores Diabetes Skin Cancer

14. Are you sensitive to scents, oils, or lotions? YES NO If yes, explain: \_\_\_\_\_

15. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA, Salicylic Acid, or any Vitamin A/Retinol derivative? YES NO If yes, have you used any within the last 3 months? YES NO

16. Have you ever used an acne medication? If yes, when/which one? \_\_\_\_\_

17. Have you had any of the following cosmetic procedures within the last two weeks (please circle all that apply)?

Cosmetic Surgery Botox Fillers Collagen Injections LED Light Treatment Laser Treatments Waxing

IPL/BBL Treatment Microdermabrasion Chemical Exfoliation Facial/Extractions Spray Tan

Hair Treatment Permanent Cosmetics

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### Skin Care Consent Form

I certify that the above information is correct to the best of my knowledge. In accordance with the law, esthetics/skin care therapy cannot cure, treat, prevent, or diagnose any condition. These treatments are used as regimens for improving skin appearance and wellness. Information exchanged during any session should be given at my own discretion.

Because certain esthetic treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the skin care therapist updated as to any changes in my health prior to any future sessions and understand that there shall be no liability on the therapist's part nor on the part of Scottsdale Skin Renewal and its affiliates should I fail to do so.

I fully understand that the therapist performs the services within the parameters of esthetics, using skin care treatments and therapies. I fully understand that the esthetics therapist is not an allopathic doctor, dermatologist, or psychiatrist and does not portray himself/herself to be.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the products and/or techniques may be adjusted to my level of comfort.

By signing below, I acknowledge that I have read and understand all parts of this consent form, and that I have had the opportunity to ask any questions with regard to any services or therapies offered. All client information is confidential.

Client Name Printed \_\_\_\_\_

Client Signature \_\_\_\_\_

Date \_\_\_\_\_