Client Intake Form

CLIENT INFORMATION

Name:

Address:

City: State: Zip Code:

Phone #:

Email:

Would you like to be added to our email list for specials and discounts? ☐ Yes ☐ No

MEDICAL HISTORY

Please check all that apply:

- ☐ Acne
- ☐ Cancer/Chemotherapy/ Radiation
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Eczema
- ☐ Fungal Condition
- ☐ Hives/Herpes/Shingles
- ☐ Inflammation
- ☐ Loss of Sensation
- ☐ Pregnant/Breast Feeding
- ☐ Psoriasis
- ☐ Rashes
- ☐ Recent Surgical Incisions
- ☐ Seborrhea
- ☐ Skin Cancer
- ☐ Skin Conditions/ Disorders
- ☐ Warts
- ☐ Unhealed Wounds
- ☐ Watery Eyes/ Seasonal Allergies
- ☐ Other _____

_____

_____

Are you currently taking any medications that may affect your skin? ☐ Yes ☐ No

If yes, please explain:

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain:

SKIN CARE HISTORY

Please describe your skin type:

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Have you had any facial or dermatology services in the past 30 days? ☐ Yes ☐ No

If yes, please explain:

Have you used any Bleaching, Retin-A, AHAs or Retinol/Vitamin A products in the last 90 days? ☐ Yes ☐ No

If yes, please explain:

Have you had any Botox, Restylane, Juvederm or Collagen injections within the last 6 months? ☐ Yes ☐ No

If yes, please explain:

Any history of Accutane (isotretinoin) use? ☐ Yes ☐ No

If yes, please explain:

Do you frequently use tanning beds or have had any excessive sun/UV exposure within the last 4 weeks? ☐ Yes ☐ No

If yes, please explain:

SKIN CONCERNS

Please check all that apply:

- ☐ Acne
- ☐ Blackheads
- ☐ Broken Capillaries
- ☐ Comedones
- ☐ Cherry Angioma
- ☐ Discoloration
- ☐ Dryness/Dull Skin
- ☐ Eczema
- ☐ Fine Lines/Wrinkles
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Keloids
- ☐ Milia
- ☐ Oily Skin
- ☐ Psoriasis
- ☐ Redness
- ☐ Rosacea
- ☐ Scarring
- ☐ Sensitivity
- ☐ Sun Damage
- ☐ Thin
- ☐ Unwanted Hair
- ☐ Other _____

_____

I understand that this form and it's data are completely confidential. The information I have provided regarding my medical history is accurate to the best of my knowledge, and I affirm I do not have any ailments or conditions that would make this treatment/procedure incompatible with my health and wellbeing. By signing this form, I certify that I have been given the opportunity to ask any questions I may have, and those questions have been answered. I agree to inform my Esthetician/Technician if I experience any pain, discomfort, or sensitivities during treatment, allowing for them to make the appropriate adjustments. I agree to waive all liability towards my Esthetician/Technician and Emergent Esthetics, for any possible harm or injury in the case of my failure to disclose any and all/past and present health conditions.

Client Signature: Date: