WEBER & WEEKLEY
Makeup-Skincare
CLIENT INTAKE FORM

CLIENT INFORMATION

Name: ______________________ Date: __________

Date of birth: __________ Age: ______ ☐ Female ☐ Male

Address: ______________________

City: __________ State: ______ Zip: __________

Phone: __________ Email: ______________________

Emergency contact: __________ Phone #: __________

How did you hear about us? ______________________

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

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

- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Heart condition
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hyper pigmentation
- ☐ Hypo pigmentation
- ☐ Hysterectomy
- ☐ Immune disorders
- ☐ Insomnia
- ☐ Keloid scarring
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Metal bone pins/plates
- ☐ Phlebitis, blood clots
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Seborrhea
- ☐ Thyroid condition
- ☐ Pace Maker
- ☐ Warts

Any other condition: ______________________

Notes:

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Any known allergies? ☐ No ☐ Yes: ______________________________

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: ______________

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Have you ever had a facial treatment before? ☐ No ☐ Yes

If yes, please explain: ______________________________

What would you like to achieve from your treatment today?

____

SKIN CARE

Please Check Current Products You Use:

- ☐ Eye Make-Up Remover
- ☐ Cleansing Cream
- ☐ Facial Soap
- ☐ Skin Toner/ Astringent
- ☐ Body Soap
- ☐ Eye Cream
- ☐ Day Cream
- ☐ Night Cream
- ☐ Neck lotion
- ☐ Hand cream
- ☐ Mask
- ☐ Facial Scrub
- ☐ Exfoliants
- ☐ Body Lotion
- ☐ Body Scrub

SKIN HISTORY

What is your skin type?	☐ Normal	☐ Oily	☐ Dry	☐ Combo	☐ Unsure
Your exposure to the sun?		☐ Never	☐ Light	☐ Moderate	☐ Excessive
What type of foundation do you wear?		☐ Liquid	☐ Cream	☐ Powder	☐ None
How does your skin heal?		☐ Fast	☐ Slow	☐ Scars	☐ Pigments
Do you get bruises easily?		☐ No	☐ Yes		

SKIN CONCERNS

- ☐ Acne
- ☐ Blackheads
- ☐ Broken Capillaries
- ☐ Comedones
- ☐ Cherry Angioma
- ☐ Discoloration
- ☐ Dryness/Dull Skin
- ☐ Eczema
- ☐ Fine lines/Wrinkles
- ☐ Hyper pigmentation
- ☐ Hypo pigmentation
- ☐ Keloids
- ☐ Milia
- ☐ Oily Skin
- ☐ Psoriasis
- ☐ Redness
- ☐ Rosacea
- ☐ Scarring
- ☐ Sensitivity
- ☐ Sun Damage
- ☐ Thin Skin
- ☐ Unwanted Hair
- ☐ Other: ______________

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Have you ever used acne medication? ☐ No ☐ Yes

If yes, when? ____________ Which drug? ____________

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? ☐ No ☐ Yes, please describe: ____________

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

☐ No ☐ Yes, please describe: ____________

By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.

____________ *Esthetician (signature)*

____________ *Client Name (signature)*

____________ *Date*

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CLIENT CONSENT FORM

I hereby consent to and authorize ______________________________ to perform the following procedure: ____ .

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by:

____ .

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

By signing below I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

This agreement will remain in effect for this procedure and all future follow-ups conducted by the technician. I understand that this consent agreement is legal and binding. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to the brow lamination procedure, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows:

____

By his or her signature below, he or she ratifies and consents to this procedure under these terms.

______________________________ 　　　　　　______________________________

Esthetician (signature) 　　　　　　*Client Name (signature)*

____

Date