Date:_____

Medical Intake Form

Name:_____ Birth Date:_____

Address: _____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Work Phone:_____

E-Mail Address:_____

Emergency Contact: (Name & Phone)_____

Primary Physician: _____

Do we have permission to contact you by phone or leave messages: _____Yes   _____No

Preferred method of contact: _____ Phone   _____Text   _____E-Mail

Do we have permission to show your photos for educational purposes? _____Yes   _____No

<u>Concerns</u>

What concerns you most about the overall appearance of your skin? (check all that apply)

___Acne	___Acne Scarring	___Age Spots
___Blackheads	___ Body Acne	___Broken Blood Vessels
___Bumps on back of arms	___Cellulite	___Cysts/Nodules
___Dehydrated Skin	___Dull Complexion	___Excessive Facial Hair
___Facial Veins	___Fine Lines/Wrinkles	___Frequent Breakouts
___Large Pores	___Loss of Lashes/Brows	___Melasma/Brown Spots/Patches
___Oily Skin	___Redness	___Rough/Uneven Skin Texture
___Rosacea	___Sagging Skin	___Sun Damage

___Under Eye Puffiness/Dark Circles   ___Other:_____

_____

How would you describe your skin? ___Oily   ___Dry   ___Combination   ___Sensitive

How would you describe your stress level? ____Little   ____Moderate   ____High   ____Severe

Do you feel your stress level may be affecting the health of your skin? _____Yes   _____No

Are you in good health overall? _____Yes   _____No Concerns:_____

<u>History</u>

Are you currently under the care of a physician? ___Yes ___No Explain:_____

_____

Do you have any allergies to foods or medications? ___Yes ___No Explain:_____

_____

Are you currently on any medications either topical or oral? ___Yes ___No If yes, please list:

_____

_____

Ethnic Background (Parents, Grandparents and Great Grandparents): _____

_____

_____

How do you heal after an acne breakout, cut or scratch? _____ No scar _____ Red _____ Brown (PIH)

Do you smoke? ___Yes ___No

Are you prone to cold sores? ___Yes ___No If yes, date of last cold sore? _____

Do you have an allergy to Latex? ___Yes ___No

Do you tan in the sun or in tanning beds/booths? ___Yes ___No

Please check the skincare products you are currently using:

___Cleanser ___Toner ___Serum ___Scrub ___Mask ___Eye Cream ___Moisturizer

___Sunscreen ___Self Tanner ___Concealer ___Makeup ___Other_____

Anything else we should know:_____

_____

_____

The answers I have provided are true and correct to the best of my knowledge.

_____   _____
Client Signature   Date

_____   _____
Provider Signature   Date

Informed Consent

I, _____ give my consent for the following procedure:

dermaplaning to be performed by _____.

Dermaplaning is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built up dead skin cells and vellous hair. Following treatment skin will be smoother, softer and better able to absorb the active ingredients in treatment and home care products.

I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellous hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts.

I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

While every precaution will be taken to avoid nicks, cuts and scratches, I understand the risks and consent to treatment today.

_____   _____
Name   Signature

_____   _____
Date   Witness

Client Name:_____ **Date:**_____

Treatment Record

Concerns:_____

Desired Outcome of Treatment:_____

Medical History Reviewed? Yes No   Informed Consent Signed? Yes No   Photos? Yes No

Skin Analysis:_____

Service(s) Provided: _____

Areas Treated: Face   Neck   Décolleté Body:_____

Cleanser:_____ Skin Prep/Toner:_____

Exfoliation: Scrub   Dermaplaning Microdermabrasion Enzyme   Peel   Other:_____

Details: _____

Peel: _____ # of Layers:_____   Time:_____ Heat Level (1-10): _____

Extractions: Yes   No Details:_____

Mask: Yes   No   Details: _____

Other Modalities: Steam   Clarisonic   SkinScrubber   MicroCurrent   LED   MicroNeedling

HighFrequency   Galvanic   UltraSound   UltraSonic   Oxygen Other:_____

Settings/Details:_____

Serum(s):_____ EyeCream:_____

Moisturizer:_____ SPF:_____

Notes:_____

_____

Products Recommended:_____

Products Purchased:_____

_____

Next Treatment:_____Date:_____

Follow Up Date:_____ Result:_____

Provider:_____