CONFIDENTIAL INTAKE FORM – SKIN CARE/ESTHETICS

Name _____ Date _____

Address_____

City, State, Zip

_____

Home Phone _____ Work/CellPhone_____

Profession

_____

Email Address _____ Date of Birth _____

Emergency Contact _____ Phone _____

1. Have you ever received professional skin care/esthetics treatments? Yes / No If yes, what type_____

2. Have you been under the care of any physician, dermatologist, or other medical 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 any topical medication or exfoliating acids like salicylic or glycolic? (Yes / No) If yes, explain:

_____

5. Have you ever had an adverse reaction to a cosmetic product? (Yes / No) If yes, explain:

_____

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

_____

7. Do you currently use any special treatments? (eye , scrubs, masks, etc.)

_____

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. How many glasses/cups of water do you drink daily?

_____

12. On a scale of 1-10, how would you rate your current stress level? (low) 1 2 3 4 5 6 7 8 9 10 (HIGH)

13. Have you ever been treated for: (Circle all that apply)

Acne Depression Skin Disease High Blood Pressure Frequent Cold Sores Diabetes Skin Cancer Hormone Imbalance Hepatitis Herpes Skin Lesions Keloid Scaring Metal Bone Pins/Plates

14. Do you wear contact lenses? (Yes / No) and Are you wearing them now? (Yes / No)

15. If you wear a hormone or nicotine patch, please indicate which kind and where you wear it:

_____

16. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid, or any Vitamin A/Retinol derivative? Yes / No If yes, have you used these products within the last 3 months? Yes / No

17. Have you ever used an acne medication? If yes, when and which one? _____

18. Please list any allergies:_____

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 esthetics 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 should I fail to do so.

The therapist reserves the right to refuse service to anyone for any reason.

I fully understand that the therapist performs her 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/intake 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_____