Client Intake Form for Permanent Makeup

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

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

How did you hear about us?

Medical History

Do you currently or have you had any of the following? Please check all that apply:

☐ Autoimmune Disorder	☐ Aids/HIV	☐ Bleeding Disorder
☐ Brow/Lash Tinting	☐ Cancer	☐ Cardiac Valve Disease
☐ Chemical Peels	☐ Chemotheraphy	☐ Hypertrophic Scarring/Keloids
☐ Pregnant/Breastfeeding	☐ Depression	☐ Diabetes
☐ History of MRSA	☐ Hemophilia	☐ Hepatitis
☐ Herpes/Cold Sores	☐ Radiation	☐ Mood Altering Disorder
☐ Serious Heart Condition	☐ Other: _____	☐ Glaucoma

Do you wear contact lenses? Yes ☐ No ☐

Do you have any other allergies? Yes ☐ No ☐

If yes, please list:

Are you currently taking any medications? Yes ☐ No ☐

Have you had any of the following surgeries? Please check all that apply:

☐ Blepharoplasty (eyelid surgery) — If yes, when?

☐ Forehead/Brow lift — If yes, when?

☐ Lasik eye surgery — If yes, when?

Are you currently on any blood-thinning prescription or non-prescription drugs? Yes ☐ No ☐

If yes, what kind?

Are you currently taking any medications? Yes ☐ No ☐

If yes, what kind?

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

If yes, please explain:

Have you had any permanent or semi-permanent makeup services completed previously? Yes ☐ No ☐

If yes, please explain:

Have you used Retin-A, Renova, AHAs or Retinal products in the last three months? Yes ☐ No ☐

If yes, please explain:

Have you received Botox, Lip Fillers, Restylane, Juvéderm or Collagen injections in the last 6 months? Yes ☐ No ☐

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 I 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.

Name Printed	Signature	Date
Technician Name	Signature	Date