Confidential
Client Intake Form

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

Please check all that apply:

☐ Acne	☐ Arthritis	☐ Depression
☐ Diabetes	☐ Eczema	☐ Epilepsy
☐ Fever Blisters	☐ Heart Condition	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Hyper Pigmentation
☐ Hypo Pigmentation	☐ Insomia	☐ Low Blood Pressure
☐ Lupus	☐ Sinus Infection	☐ Surgery: _____
☐ Pregnant	☐ Psoriasis	☐ Rashes
☐ Seborrhea	☐ Shingles	☐ Skin Cancer
☐ Hype/Hypo Thyroid	☐ Warts	☐ Other: _____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please explain:

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

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Skin Care History

Check the products that you currently use (please select all that apply):

☐ Body Lotion	☐ Body Soap	☐ Body Scrub
☐ Cleansing Cream	☐ Day Cream	☐ Eye Makeup Remover
☐ Eye Cream	☐ Exfoliants	☐ Facial Soap
☐ Facial Scrub	☐ Hand Cream	☐ Neck Cream
☐ Night Cream	☐ Skin Toner/Astringent	☐ Other: _____

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache
☐ Inflammation ☐ Insomia ☐ Muscle Cramps ☐ Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐ Acne/Breakouts ☐ Blackheads/Whiteheads
☐ Broken Capillaries ☐ Clogged Pores
☐ Dark Spots ☐ Dryness
☐ Excessive Oil/Shine ☐ Redness
☐ Rosacea ☐ Scarring
☐ Sun Damage ☐ Uneven Skin Tone
☐ Unwanted Hair ☐ Wrinkles/Fine Lines
☐ Other: _____

Have you been under the care of a dermatologist within the past year? Yes ☐ No ☐

If yes, please explain:

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

If yes, please explain:

Have you received Botox, Restylane, 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