Client Intake Form – Esthetics

Name_____ Date of birth:_____
Address:_____ City:_____ State:_____ Zip:_____
Phone: (home)_____ (cell)_____ (work)_____
Email:_____ Emergency contact:_____ Ph:_____
Occupation:_____ Age:_____ Male Female
Physician/Dermatologist: _____ Ph:_____
Referred by: _____

Please answer the following questions.

1. Have you ever had a facial before? ☐ Yes ☐ No
2. Are you under a physician's care for any current skin condition or other problem? ☐ Yes ☐ No
3. Are you pregnant? ☐ Yes ☐ No
4. Are you taking birth control? ☐ Yes ☐ No
   If "Yes", please specify.
   _____
5. Are you presently using (or have used in the past) Accutane, Retin-A, Renova, Adapalene Hydroxl Acid or any other Retinol/Vitamin A derived products? ☐ Yes ☐ No
   If "Yes", please specify, which, when and how long?
   _____
   _____
6. Are you presently taking any medications? ☐ Yes ☐ No
   If so, please list
   _____
   _____
7. Do you smoke or vape? ☐ Yes ☐ No
   If so, for how long:
   _____
8. In the last month, have you:
   A. Botox ☐ Yes ☐ No
   B. Restylane ☐ Yes ☐ No
   C. Collagen injections ☐ Yes ☐ No
   D. Chemical peels ☐ Yes ☐ No
   E. Laser treatments ☐ Yes ☐ No
   F. Microdermabrasion ☐ Yes ☐ No
9. Have you recently used any self- tanning lotions, creams or treatments? ☐ Yes ☐ No
10. Have you recently used a tanning bead or had sun exposure that changed the color of your skin? ☐ Yes ☐ No
    If so, please specify: ____
    _____
    _____

Please check if you have any of the following:

- ☐ Asthma
- ☐ Cardiac problems
- ☐ Depression
- ☐ Herpes
- ☐ Fever blisters
- ☐ Headaches
- ☐ Migraines
- ☐ Anxiety
- ☐ Epilepsy
- ☐ Hysterectomy
- ☐ Skin Diseases
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Sinus problems
- ☐ Psoriasis
- ☐ Immune Disorders
- ☐ Lupus
- ☐ Eczema
- ☐ Pace maker
- ☐ HIV/AIDS
- ☐ HPV/Genital wart
- ☐ Metal bone, pins, or plates

Please check if you have had an allergic reaction to any of the following:

- ☐ Cosmetics
- ☐ Fragrances
- ☐ Animals
- ☐ Drugs
- ☐ AHAs
- ☐ Food
- ☐ Latex
- ☐ Iodine
- ☐ Medications
- ☐ Shellfish
- ☐ Sunscreens
- ☐ Pollen
- ☐ Gluten
- ☐ Dairy/Casein
- ☐ Other _____

_____

Please continue to the next page

Client Facial Intake Form – Esthetics

What areas of concern do you have regarding your: (Please mark all that apply)

Skin

- ☐ Breakouts/Acne
- ☐ Sun damage
- ☐ Rosacea
- ☐ Flaky skin
- ☐ Sun/liver/brown spots
- ☐ Uneven skin tone
- ☐ Excessive oil/shine
- ☐ Dull/dry skin
- ☐ Redness/rudiness
- ☐ Sensitivity
- ☐ Blackheads/whiteheads
- ☐ Wrinkles/fine lines
- ☐ Broken capillaries
- ☐ Dehydrated
- ☐ Other _____

Eyes

- ☐ Dehydrated
- ☐ Dark circles
- ☐ Wrinkles
- ☐ Other _____
- ☐ Puffiness

Lips

- ☐ Dehydrated
- ☐ Cracked/chapped lips
- ☐ Other _____

Have you had any of these hair removal methods performed in the last six weeks: (Please mark all that apply)

- ☐ Shaving
- ☐ Stringing
- ☐ Waxing
- ☐ Electrolysis
- ☐ Plucking
- ☐ Tweezing
- ☐ Depilatories
- ☐ Other _____

Please list all skin care products you are currently using. (List brand names if known)

_____

_____

_____

_____

I understand that services offered are not a substitute for medical care; and any information provided by the technician/ esthetician/skin care professional, is for educational purposes only and are not diagnostically prescriptive in nature. I understand that the information herein is to aid the technician/esthetician/skin care professional in giving better service and is completely confidential. I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Client name (Printed):_____

Client Name (Signature):_____ **Date:**_____