CLIENT INTAKE FORM

Date: _______________
Name:____
Email:____
Phone (where we can reach you to confirm): __________________________
Date of Birth___________________________________ Age: ______________

Skin Information

What products are you currently using on your face?

Morning: Cleanser-______________________________
Toner- ______________________________
Moisturizer-____________________________
Sun block- SPF# ______________________
Other- ______________________________

Night: Cleanser-______________________________
Toner- ______________________________
Moisturizer-____________________________
other- ______________________________

Do you sunbathe or use tanning beds? ☐ Y ☐ N
When you sunbathe or get accidental sun, how does you skin respond?

☐ Always burn, never tan ☐ Burn first, tan average ☐ Sometimes burn, tan well
☐ Occasionally burn, tan easily ☐ Rarely burn, tan very easily ☐ Never burn, always tan

How much water do you drink a day? ☐ Little ☐ Average (64 oz) ☐ A lot (1 gal)
How much caffeine do you drink a day? ☐None ☐Little ☐ Average ☐ A lot
Do you smoke? ☐ Y ☐ N
Check any conditions your skin may experience throughout the day:

☐ Oily all over face ☐ Shiny T-Zone ☐ Tightness ☐ Flakiness ☐ Redness

Has your skin ever reacted to products during a facial? ☐Y ☐N
Does your face turn red easily? ☐Y ☐N
Primary concerns of your skin: ____

Medical Information

Check next to any conditions for which you have been treated or you are currently treating:
☐ Acne ☐ Skin Pigmentation ☐ Rosacea ☐Cancer ☐ Diabetes ☐ Pacemaker
☐ Epilepsy ☐ Thyroid ☐ Cold Sores ☐ Eczema ☐ Psoriasis ☐ Keloid Scars
☐ Steroids ☐ Hormone Replacement Therapy ☐ Hysterectomy ☐ High Blood Pressure
☐Other____
List any current medications : ____
List all food and environmental allergies: ____
☐ Currently Pregnant ☐ Currently Nursing

Check if you have had any of the following:
☐ Cosmetic Surgery ☐ Botox ☐ Fillers ☐ Retin-A ☐ Accutane ☐Laser Hair Removal ☐Permanent Make-up
☐ Chemical Peels ☐ Microdermabrasion ☐ Laser Resurfacing ☐ Waxing ☐ Micro current

____ ____
Client Signature *Therapist Signature*

- *Please review and sign on each visit.*
- *Al information is confidential and will be shredded after 6 months*

CLIENT INTAKE UPDATE

DATE	*CLIENT SIGNATURE*		*THERAPIST*