Client Facial Intake Form

Date: ____________________

Name: ____ Date of Birth: ____________

Address: ____

Home Phone: ________________________________ Business Phone: ______________________________

Cell Phone: ________________________________ E-mail address: ______________________________

Emergency contact: ________________________________ Phone: ______________________________

Your Health

Are you currently under the care of a physician, dermatologist or other medical professional?

No Yes, explain: ____

____

Any recent surgeries, including plastic surgery? No Yes, explain: ____________________

____

Have you had any of these health conditions in the past or present? (Please check all that apply)

Allergies	☐	Immune disorder	☐
Asthma	☐	Insomnia	☐
Arthritis	☐	Keloid scarring	☐
Active Infection	☐	Lupus	☐
Cancer	☐	Metal implants/pacemaker	☐
Claustrophobia	☐	Phlebitis, blood clots, poor circulation	☐
Diabetes	☐	Psychological treatment	☐
Eczema	☐	Seizure disorder	☐
Epilepsy	☐	Sinus problems	☐
Fever blisters/cold sores	☐	Skin disease/lesions	☐
Headaches	☐	Spinal Injury	☐
Heart problem	☐	Systemic disease	☐
Hepatitis	☐	Thyroid condition	☐
Herpes	☐	Varicose veins	☐
High blood pressure	☐	Other (please list)	☐
HIV/AIDS	☐	______________________________	
Hormone Imbalance	☐	______________________________	
Hysterectomy	☐	______________________________	

Do you smoke? No Yes

Do you follow a restricted diet? No Yes

What is your stress level? High Medium Low

Are you pregnant? No Yes

Are you undergoing any hormone replacement therapy? No Yes

List any medications, supplements, and vitamins you take regularly: ______________________________

____

Your Skin

Have you ever had a facial before? No Yes, when? ______________________

Which of the following best describes your skin type? (Please circle one type number)

I	Creamy complexion	Always burns easily, never tans
II	Light complexion	Always burns, tans slightly
III	Light/Medium complexion	Burns moderately, tans gradually
IV	Medium complexion	Seldom burns, always tans well
V	Brown complexion	Rarely burns, deep tan
VI	Black complexion	Never burns, deeply pigmented

Have you ever had chemical peels, laser or microdermabrasion? No Yes

In the last month? No Yes

Do you use Retin-A, Renova, Retinol/Vitamin A derivative products? No Yes

In the last 3 months? No Yes

Have you used an acne medication? No Yes, when? ______________________

Which drug? ______________________

Have you had Botox, Restylane or any injectable? No Yes, when? ______________

Do you have any special skin problems or concerns? No Yes, specify ______________

____

What skin care products are you currently using? (Please list brands where known)

Cleanser ______________________ Mask ______________________

Toner ______________________ Serum ______________________

Moisturizer ______________________ Eye product ______________________

Sunscreen ______________________ Other ______________________

Exfoliation/Scrub ______________________

What would you like to achieve from your treatment today? ______________________

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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. I am aware that it is my responsibility to inform the Esthetician/ skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: ______________________________ Date: ______________