

Welcome



Skin Care Intake Form

Personal Information:

Name Phone (Cell) (Home)
Address City/State/Zip
DOB Email Occupation
Emergency Contact Relationship Phone
Sex: Male Female Other How did you hear about us?

Medical Information:

Do you have any allergies? Yes No If yes, please explain
Are you taking any medication? Yes No If Yes, Please list name and use:
Are you currently Pregnant? Yes No If yes, How far along? Any High Risk factors?
Do you smoke? Yes No If yes, how often?
Are you currently under the care of a physician or dermatologist for skin care? Yes No Explain:
Have you had any surgeries in the last 6 months? Yes No If yes, explain:
Do you have any skin problems or concerns pertaining to your face or body? Yes no explain
Have you experienced Botox, Restylane, or Collagen Injections? Yes No Please Specify:
How much UV exposure do you get? (tanning bed and sun)

Client Self Assessment:

- Scars Stretch Marks Hyper Pigmentation Acne Oiliness Psoriasis Blackhead Vein/Circulation Problems
Whiteheads Eczema Milia Cellulite Cancer Diabetes Hysterectomy AIDS/HIV Spinal Injury Lupus
Keloid Scarring Menopause High/Low Blood Pressure Claustrophobia Pacemaker/Defibrillator Rosacea
Metal Implants/Pins Heart Disease Thyroid Disorder Hormone Imbalance Cold Sores Fibromyalgia Bruising
Hepatitis A/B/C Blood Clot Disorder Epilepsy/Seizures Migraines/Headaches Skin Disease/ Disorder Anxiety
Depression Immune Disorder Blush/Redden Easily Explain any conditions you have:

Are you allergic to any of the following:

- Cosmetics Fragrance Animals Drugs AHAs Food Latex Lodine Medication Shellfish
Sunscreens Pollen Other Explain if needed:

What skin care products are you currently using? (list brand names if known):

Are you using any products containing:

- Retin-A Renova Retinol/Vitamin A Adapalene Hydroxy Acid Glycolic Acid AHA/BHA Salicylic Acid
Lactic Acid Accutane Or any other prescription or over the counter skin care products: