HOW TO USE THESE FORM TEMPLATES

HELLO! THESE FORM TEMPLATES ARE HERE TO HELP YOU CREATE YOUR OWN INTAKE FORMS AND INFORMED CONSENTS FOR YOUR PERMANENT MAKEUP BUSINESS. PLEASE KEEP THE FOLLOWING IN MIND:

THIS IS A “VIEW ONLY” FILE. TO EDIT, SIMPLY CREATE YOUR OWN COPY IN CANVA (FILE > MAKE A COPY).

CUSTOMIZE THE TEMPLATES WITH YOUR BRANDING: COLORS, LOGO, AND LANGUAGE THAT SUITS YOUR STUDIO'S VIBE.

REVIEW EACH SECTION CAREFULLY TO ENSURE IT ALIGNS WITH YOUR SPECIFIC BUSINESS POLICIES AND PROCEDURES.

WE’RE HERE TO PROVIDE THESE TEMPLATES, BUT WE CAN’T TAKE RESPONSIBILITY FOR ANY ISSUES THAT MAY ARISE FROM THEIR USE. PLEASE ENSURE THAT YOUR FORMS COMPLY WITH LOCAL LAWS AND REGULATIONS.

BY USING THESE TEMPLATES, YOU AGREE TO TAILOR THEM FOR YOUR UNIQUE NEEDS.

ENJOY CREATING!

YOUR
LOGO
HERE

PERMANENT MAKEUP
client intake form

CLIENT INFORMATION:

Name: Date:

Date of birth: Age:

Address:

City: Postal Code:

Email Address:

Phone: Emergency Contact:

Have you ever had a cosmetic tattoo or permanent makeup procedure before? If yes, when was your last procedure?

○ Yes ○ No

Describe what you would like to improve or change about the area you are getting treated (e.g., shape, color, density, thickness):

Do you have any of the following in the treatment area?

Moles or raised areas	○ Yes	○ No
Piercings	○ Yes	○ No
Lash extensions of any kind	○ Yes	○ No

MEDICAL HISTORY

Mark any conditions you currently have or have had in the past:

- ○ Hair Loss
- ○ Anemia
- ○ Cold sores or fever blisters
- ○ Sensitivity to cosmetics
- ○ Prolonged bleeding
- ○ Diabetes
- ○ Trichotillomania
- ○ Joint Replacements
- ○ Healing problems
- ○ Epilepsy
- ○ Eczema
- ○ Low Blood pressure
- ○ High Blood Pressure
- ○ HIV
- ○ Hemophilia
- ○ Thyroid disturbances
- ○ Cancer
- ○ Hepatitis
- ○ Fainting spells or dizziness
- ○ Circulatory Problems
- ○ Hypertrophic or keloid scars
- ○ Liver Disease
- ○ Alopecia
- ○ Tumors, growths, cysts
- ○ Other

_____

_____

Are you taking any medications, vitamins, including over-the-counter or prescription drugs? If yes, please list them below

○ Yes ○ No .....

Have you experienced Botox, Restylane or Collagen injections?

○ Yes ○ No .....

Within the last nine months, have you undergone any surgery or plastic surgery?

○ Yes ○ No .....

Have you ever had a cold sore/fever blister?

○ Yes ○ No .....

If yes, contact your physician for a preventative prescription capsule to prevent a cold sore/fever blister.

Have you ever had an allergic reaction to any of the following (please circle):

- ○ Latex
- ○ Vaseline
- ○ Food
- ○ Paints
- ○ Metals
- ○ Lidocaine
- ○ Lanolin
- ○ Crayons
- ○ Medication
- ○ Glycerin
- ○ Hair Dyes
- ○ Fragrance
- ○ Latex
- ○ Aspirin
- ○ Other

_____

Do you scar easily?

○ Yes ○ No

Do you bruise/bleed easily?

○ Yes ○ No

Do you have any specific concerns or questions about the procedure?

What are your expectations and goals for the treatment?

FEMALE CLIENTS

Are you taking birth control?

○ Yes ○ No

Are you pregnant or trying to become pregnant?

○ Yes ○ No

Are you undergoing any hormone replacement therapy?

○ Yes ○ No

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 skin care professional from liability and assume full responsibility thereof.

Client Printed Name	Clients Signature	Date
Esthetician Name	Esthetician Signature	Date