CLIENT INTAKE FORM

Last Name: _____ First Name: _____ Date: ___ / ___ / _____

Email: _____ Phone: (_____) _____ – _____ Birthday: ___ / ___ / _____

Address: _____

City/State: _____ Zip: _____ Occupation: _____

Climate _____ Sex: ☐ Female ☐ Male

How did you hear about us? _____ Referral: _____

What skin improvements would you like to see? _____

Women: Are you pregnant or lactating? ☐ Yes ☐ No Men: Do you experience irritation from shaving? ☐ Yes ☐ No

HEALTH HISTORY

Cancer (skin or other)	☐ Yes ☐ No	Infection (virus, bacteria)	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Autoimmune Disease (Lupus, RA, MS etc.)	☐ Yes ☐ No	Eye Disorders	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Chronic Pain (fibromyalgia, migraine etc.)	☐ Yes ☐ No
Neck/Back Pain	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Heart Problems/Blood Pressure	☐ Yes ☐ No	Hormone Issues (PCOS, Endometriosis, menopause)	☐ Yes ☐ No
Allergies (please list)	☐ Yes ☐ No	_____	

Explanation/further details: _____

_____

SKIN HISTORY

Recent surgery (general) the last 6 months?	☐ Yes ☐ No	Laser treatments/IPL within the last month?	☐ Yes ☐ No
Recent surgery (cosmetic) the last 6 months?	☐ Yes ☐ No	Chemical peels within the last month?	☐ Yes ☐ No
Recent cosmetic injections (Botox, filler etc.)?	☐ Yes ☐ No	Loss of skin sensation?	☐ Yes ☐ No
Recent hair removal? (waxing, laser electrolysis)	☐ Yes ☐ No	Recent sunburn?	☐ Yes ☐ No
Are you under a doctor's care for skin issues?	☐ Yes ☐ No		

DAILY MEDICATIONS

☐ Accutane	☐ Retin-A	☐ Diabetes	☐ Thyroid
☐ Antibiotic	☐ Anti-Depressant	☐ Heart/Blood Pressure	☐ Corticosteriod
☐ Sleep/Anxiety	☐ Pain/NSAIDs	☐ Blood Thinner	☐ Anti-Androgen
☐ Hormones	☐ Skin Disease	☐ Other: _____	

DAILY SKIN CARE (1x, 2x, weekly, varies)

☐ Cleanser/Toner	Frequency _____	☐ Moisturizer	Frequency _____
☐ Exfoliant/Scrub	Frequency _____	☐ SPF	Frequency _____
☐ Serum/Oil	Frequency _____	☐ Night Cream	Frequency _____
☐ Mask	Frequency _____	☐ Prescription	Frequency _____
☐ Eye Cream	Frequency _____	☐ Neck Cream	Frequency _____

Reasons for use (i.e. improves wrinkles etc.): _____

_____

CLIENT INTAKE FORM (Cont'd)

LIFESTYLE

Do you sleep from 6-8 hours a night?	☐ Yes ☐ No	If no, how many hours? _____
Do you smoke?	☐ Yes ☐ No	Cigarettes or other: _____
Do you have chronic stress?	☐ Yes ☐ No	What is your level? ☐ Low ☐ Medium ☐ High
Do you exercise regularly?	☐ Yes ☐ No	☐ Cardio ☐ Weights ☐ Yoga ☐ Other: _____
Do you use hormone replacement therapy?	☐ Yes ☐ No	
Do you get daily UV exposure?	☐ Yes ☐ No	☐ 8+ hours ☐ Less than 5 hours ☐ Less than 1 hour
Do you drink more than 7 drinks a week of alcohol?	☐ Yes ☐ No	
Do you eat at least 3 servings of vegetables a day?	☐ Yes ☐ No	
Is your intake of sugar more than 100 cals a day?	☐ Yes ☐ No	(Examples: soda, desserts, other processed foods)
Do you drink more than 2 cups a day of caffeine?	☐ Yes ☐ No	
Do you drink 8-10 glasses of water a day?	☐ Yes ☐ No	
Do you take probiotics daily?	☐ Yes ☐ No	
Do you take vitamin D3 daily?	☐ Yes ☐ No	
Do you take a multivitamin daily or omega oils?	☐ Yes ☐ No	

Future Appointments/Contact:

May I call you at your phone number to confirm future appointments?	☐ Yes ☐ No
May I text you to confirm?	☐ Yes ☐ No
May I contact you via mail/email about future promotions and news?	☐ Yes ☐ No

Service Consent:

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 understand the appointment cancellation policy. 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: _____