CLIENT INTAKE

Date of Initial Visit: _____
First Name: _____ Last Name: _____
Address: _____
City: _____ State:_____ Zip:_____
Check the primary phone number to reach you concerning appointments.

□ Home_____ □ Cell _____ □ Business _____

If you would like to receive our newsletter or notification of specials, please provide your email address. _____
Birth Date:_____ Age:_____ □ Male □ Female
Occupation: _____Activities /Hobbies: _____

Referred By:

□ Health Care Provider: _____ □ Advertisement
□ Center MedSpa Employee: _____ □ Gift Certificate
□ Family or Friend: _____ □ Other: _____

In case of emergency, please notify:

Name: _____ Phone number: _____
Relationship: _____

Date of your last nail service or facial: _____
For your safety and well-being, we would like you to answer a few health related questions. This information will remain confidential.

NAIL SERVICE INTAKE

On your hands/feet, do you have:
□ Calluses □ Corns □ Ingrown Nails □ Warts □ Athlete's Foot
Does the skin on your hands or feet ever:
□ Crack □ Break □ Open □ Bleed
On your hands or feet, do you have:
□ Open Wounds □ Cuts □ Sores □ Bruises □ Tenderness
Are you diabetic? □ Y □ N
Do you have a nail infection on either your fingernails or toenails?
□ Y □ N
Have you ever been diagnosed with any of the following:
□ AIDS □ HIV □ Hepatitis A or B
Please list any known allergies to food, medicines, scents, plants/grass/trees, etc.: _____

_____
Please list any medications you are taking, including oral, topical, blood thinners, pain relievers:

_____

CLIENT INTAKE

FACIAL INTAKE

Ethnic Skin type:
□ Caucasian □ African-American □ Hispanic □ Asian □ Indian

Please list any health conditions you are experiencing: _____

Have you ever taken / currently taking: □ Retin A □ Accutane

Topical or oral antibiotics: □ Oral □ Topical Name: _____

Exercise Frequency: _____ Stress level? Low 1 2 3 4 5 6 7 8 9 10 High

How many hours of sleep per night? _____ Smoke? □ Yes □ No

How much alcohol and caffeine per day? _____ Caffeine_____ Alcohol

List supplements, allergies, recent surgeries:_____

Primary concerns: _____

UV exposure per week? (sun, tanning beds, car)_____ What SPF do you use? _____

Do you have: □ Scars □ Stretch marks □ Hyperpigmentation □ Contact lenses

Are you allergic to: □ Sulfur □ Citrus □ Collagen □ Latex □ Other: _____

Do you suffer from:

□ Acne	□ Whiteheads	□ Blackheads	□ Milia
□ Oiliness	□ Rosacea	□ Dehydration	□ Eczema
□ Cellulite	□ Vein Problems	□ Cold Sores	□ Psoriasis: _____
□ Other: _____			

Have you ever received any of the following treatments?

□ Facial	□ Waxing/date: _____	□ Microdermabrasion	□ Laser Surgery
□ Chemical Peels	□ Lash/Brow Tint	□ Laser hair removal	□ Vein treatments

Please select the box that applies to you:

□ Never tan, always burn	□ Tan with difficulty, usually burn	□ Average tan, sometimes burn
□ Easily tan, rarely burn	□ Never burn	

By signing below, you attest that you have provided accurate and current information on this form and have answered all medical and health-related questions truthfully and completely. Your signature also certifies that you understand Center MedSpa reserves the right to deny service to any client due to a health condition he or she has that may pose potential risk to practitioners or other clients, including those that pose a risk of potential contamination to service areas. Signing below verifies that you understand that you are responsible for informing Center MedSpa staff of any and ALL changes to your health condition as it pertains to any question on this form or any potential public health risk that may arise from any change in your health condition.

Patient Name_____ Patient Signature _____ Date _____

Guardian Name _____ Guardian Signature_____ Date _____