M.INT BEAUTY

CLIENT INTAKE FORM FOR PERMANENT MAKEUP

Date :

CLIENT PROFILE

First Name :

Phone :

Date Of Birth : D D M M Y Y

Full Address :

City/State :

Postal Code :

E-Mail :

City / Country :

How did You Hear About US :

Referral :

Type of Service Today : ☐ Eyebrows ☐ Eyeliner ☐ Lip Blush ☐ Touch Up ☐ Camouflage ☐ Removal ☐ Other

HEALTH HISTORY

Cancer (Skin or Other)	☐ Yes	☐ No	Infection (Virus, Bacteria)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Eye Disorders	☐ Yes	☐ No
Autoimmune Disease (lupus, RA, MS etc.)	☐ Yes	☐ No	Chronic Pain (Migraine, etc.)	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No
Neck/Back Pain	☐ Yes	☐ No	Hormone Issues (Menopause)	☐ Yes	☐ No
Heart Problems/ Blood Pressure	☐ Yes	☐ No	Pregnancy or Breast Feeding	☐ Yes	☐ No
Infectious Disease (HIV etc.)	☐ Yes	☐ No			
Skin Conditions (eczema, rosacea, etc.)	☐ Yes	☐ No			
Allergies (Please List)	☐ Yes	☐ No			

Explanation/Further Details: _____

_____

_____

SKIN HISTORY

Recent surgery (general) the last 6 months?	☐ Yes	☐ No
Recent cosmetic surgery the last 6 months?	☐ Yes	☐ No
Recent cosmetic injections (Botox, Fillers, etc.) ?	☐ Yes	☐ No
Recent hair removal ? (Waxing, Laser, Electrolysis)	☐ Yes	☐ No
Are you under a doctors care for skin issues?	☐ Yes	☐ No
Laser Treatments/IPL within the last month?	☐ Yes	☐ No
Chemical peels within the last month?	☐ Yes	☐ No
Recent sunburn?	☐ Yes	☐ No

DAILY MEDICATIONS

☐ Antibiotic	☐ Antidepressant	☐ Diabetes	☐ Thyroid
☐ Sleep/Anxiety	☐ Pain/NSAIDS	☐ Heart/Blood Pressure	☐ Anti-Androgen
☐ Hormones	☐ Skin Disease	☐ Other:	

PERMANENT MAKEUP

Have you ever had PMU or Microblading?	☐ Yes	☐ No
Have you ever had an adverse reaction to pigments (colorant) and anesthetics	☐ Yes	☐ No
Do you scar easily or prone to keloids?	☐ Yes	☐ No

Although every precaution will be made to ensure your safety and well-being before, during and after your PMU procedure, please be aware of the possible risk below. Please initial:

_____ I understand that PMU procedure has some inherent risk or scarring to the skin area, including the skin itself, and could result in granulomas and keloid formation.

_____ I understand that if numbing anesthetics, ink colorants other solutions accidently come into contact with my eye, my eye will be flushed with water and medical attention may be required.

_____ I understand that some irritation, itching or burning may occur to the skin or eyes that comes in contact with the numbing agents and other PMU related products.

_____ I understand that there may be some residual of numbing agent left on the skin following the PMU procedure, the numbing will go away within a short time.

_____ I understand that, while every attempt will be made to provide me with my chosen style, everyone's face or body part is not symmetrical and my final results may not be exact. Less is more.

_____ I understand that over the course of 4-6 weeks, the PMU will continue to heal, and a touchup may be required to achieve the final result.

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 is supersedes and previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin or eye area from procedures received. I understand the appointment cancellation policy. The procedure I receive here are voluntary, and I release this studio, salon and/or skin care professional/ lash technician from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____