

FACIAL INTAKE FORM

Date _____

Name _____ Date of Birth _____

Address _____ Zip _____

Phone Number _____ E-mail _____

Emergency Contact _____ Phone _____

Help us do a great job for you. Please answer as well as you can.

What would you like to achieve on your skin today?

What skin care products are you currently using?

Have you had a face treatment before: No/Yes When? Comment on this.

Do you have a daily skin routine? No/Yes. If so please describe?

How would you describe your skin type?

Do you have any special skin problems or concerns pertaining to your skin? Yes/No. If yes, specify.

Check if you use any of these products?

1. Soap
2. Toner
3. Mask
4. Eye product
5. Cleanser
6. Day Moisturizer
7. Night Moisturizer
8. Exfoliator
9. Scrubs
10. Gels

11. Body Lotion

12. Sunscreen

Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain) If yes, please explain in the specify section:

Cosmetics - Medicine - Food - Animals- Sunscreens- Iodine - Pollen - AHAs - Fragrance - Shellfish - Latex - Drugs - Essential Oils- Flowers/botanicals - Other

Specify:

Have you had any of these health conditions in the past or present? (Please circle any that apply and explain)

**Cancer - Hormone imbalance -Systemic disease - High blood pressure - Thyroid condition -Diabetes
Heart problem - Varicose veins - Arthritis - Asthma - Eczema - Epilepsy -Headaches (chronic) -
Hepatitis -Herpes - Frequent cold sores - Immune disorders - HIV/AIDS - Lupus -Phlebitis- blood
clots -Poor circulation - Psychological treatment - Insomnia - Keloid scarring - Skin disease/skin
lesions - Any active infection**

Specify:

Do you follow a regular exercise program?

What is your stress level? Please circle: High Medium Low

Do you wear contact lenses?

Do you wear a pacemaker?

Do you suffer from sinus problems?

Have you ever had an adverse reaction to any skin care product?

For Females Clients

Are you pregnant or trying to become pregnant?

Any menopause problems?

Please specify for any of the above:

I am aware that it is my responsibility to inform my therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof. I understand that my therapist does not replace the recommendations of a medical physician.

Client Signature _____