FACIAL INTAKE FORM

Name _____ Date of Birth _____Date _____

Address _____Zip _____

Phone Number_____E-mail_____

Emergency Contact _____Phone_____

HISTORY

MEDICATIONS, SUPPLEMENTS, & VITAMINS	**YES**	**NO**	**DATE/LIST COMMENT**
Accutane			
Antibiotics			
Birth control pills			
Hormone replacement therapy			
Aspirin, Ibuprofen use			
Retin-A, Renova, Tretinoin			
Metrogel, MetroCream			
Glycolic acid on a regular basis			
Antidepressants			
ALLERGIES			
Medication allergies			
Food allergies			
Aspirin allergy			
Latex allergy			
Lidocaine allergy			
Hydrocortisone allergy			
Cosmetic Product allergy			
Fragrance allergy			
Essential oil allergy			
Vegetable/Nut oil allergy			
Botanical/Flowers allergy			
Salicylic Acid (BHA)			
Beeswax			
Other allergy? Please name			
CONFIRM IF APPLICABLE			
Are you pregnant?			
Diabetic			
Are you perimenopause? Are you in menopause?			
Any heart problems/conditions			
Have cancer			

	YES	NO	DATE/ LIST/ COMMENT
Asthmatic			
Epileptic			
Do you currently have cold sores, herpes			
Bleeding disorders			
Autoimmune disorders, HIV			
Pacemaker			
Implants of any kind			
Metal implants, piercings, rods, fillings			
Migraine headaches			
Glaucoma			
Cancer			
Arthritis			
Hepatitis			
Thyroid imbalance			
Active infection			
Suffer from blood clots			
SKIN CONDITIONS			
Acne			
Melasma			
Rosacea			
Do you have a diagnosed skin condition or disease			
PRIOR PROCEDURES			
Skin/laser treatments at another office			
Botox			
Fillers			
Chemical peels			
Sun exposure/tanning bed in last week? Self tanner?			
List medical issues or skin conditions not listed above			

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

CURRENT SKIN-CARE AND LIFESTYLE

how would you describe your skin type?

_____

Do you use?

Bar soap on face Yes No Brand _____

Foaming gel cleanser Yes No Brand _____

Cleansing lotion Yes No Brand _____

Cleansing cream	Yes	No	Brand _____
Toner or Astringent	Yes	No	Brand _____
Scrubs/Exfoliator	Yes	No	Brand_____
Moisturizer	Yes	No	Brand _____
Treatment serums	Yes	No	Brand _____
Eye cream	Yes	No	Brand _____
Sunscreen	Yes	No	Brand _____
Other	Yes	No	Brand _____

How often is the above routine? Circle most relevant Daily Weekly When I remember

Do you consume water daily? Yes No If yes, how many 8oz glasses of pure water a day? _____ glasses

On a weekly bases do you: (circle that apply)

Smoke Indoor/Outdoor tan Consume alcohol

Consumer caffeinated beverages Eat lots of sugar Go to bed without washing your face

Touch your face with your hands

Have you had a facial before? If so, where? _____

Approx. date: _____

Is there anything that bothers you about your skin?

Do you wear contact lenses?

Do you suffer from sinus problems?

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

What is the purpose of your visit today?

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. I understand that 24 hours notice is required for rescheduling or cancellation of appointment and with failure to do so I will be charged for the full amount of the session.

Client Signature _____