



Skincare & Body Treatment Intake Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____ Gender: Male Female Age: _____

City _____ State _____ Zip _____ Phone #: _____ Home

Email: _____ Cell

Occupation: _____ Referred by: _____

Emergency Contact: _____ Phone #: _____

1. Allergies: _____

2. Current medications (topical & oral): _____

3. Have you ever experienced any of the following conditions? (Check all that apply)

Cancer	High/Low Blood Pressure	Metal Implants/Pins	Pacemaker/Defibrillator
Diabetes	Claustrophobia	Heart Disease	Thyroid Disorder
Hysterectomy	Hormone Imbalance	Epilepsy/Seizures	Blush/Redden Easily
AIDS/HIV	Hepatitis A / B / C	Migraines/Headaches	Depression/Anxiety
Psoriasis	Rosacea	Eczema	Bruise Easily
Spinal Injury	Fever Blisters/Cold Sores	Immune Disorders	Lupus
Keloid Scarring	Blood Clot Disorder	Skin Disease/Disorder	Fibromyalgia
Menopause	Eating Disorder	Circulation Disorder	Other: _____

4. Do you smoke?

5. Do you wear contacts?

6. Do you follow a restricted diet?

7. What is your daily consumption of Water? _____ oz.

Caffeine? _____ oz.

Alcohol? _____ oz.

8. Are you currently under the care of a physician or dermatologist?

If so, explain _____

9. Any surgeries or dental work within the last 6 months?

If so, explain _____

10. Any dermal injections/fillers within the last 6 months?

If so, explain _____

11. (A) Are you using any products that contain Retin-A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A, Accutane, or any other prescription skin products?

(B) Have you used any of these products in the past 3 months?

If so, explain _____

12. Have you ever had any of the following? (Please check all that apply)

Facial	Body Scrub	Waxing	Microdermabrasion	Dermaplaning
Body Wrap	LED	Eyelash/Eyebrow Tint	Chemical Peel	Laser Resurfacing

13. Have you ever had any reaction to any skin products?

If so, explain _____

14. Do you wear sunscreen daily?

If so, what spf? _____

16. What type of skin care products do you use? _____

17. FEMALE CLIENTS ONLY:

(A) Are you currently or trying to get pregnant?

(B) Any recent changes to or from your contraceptive treatment?

If so, explain _____

CLIENT 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 am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the esthetician in giving better service and is completely confidential. The treatments I receive here are voluntary and I release this institution and/or skincare professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

Esthetician Signature: _____ Date: _____

Please print & bring to your appointment. Thank you!