Date:_____ # Skin Care & Body Treatment Intake Form

Name: _____Date of Birth:_____

Address: _____Gender: Male Female Age:___

City, Postal Code _____Home # (_____) _____

Email:_____Cell # (_____)_____

Allergies:

_____

Current medications (topical & oral)

_____

Have you ever experienced any of the following conditions? Please circle 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	**Cold Sores**	**Immune Disorder**	**Lupus**
Keloid Scarring	**Blood Clot Disorder**	**Skin Disease/Disorder**	**Fibromyalgia**
Menopause	**Circulation Disorder**	**Varicose Veins/Phlebitis**	**Other:_____**

1. Do you smoke? Y N 2. Do you wear contacts? Y N 3. Do you follow a restricted diet? Y N

What is your daily consumption of Water?_____oz Caffeine?____oz Alcohol? _____oz

Are you currently under the care of a physician or dermatologist? Y N If so, explain.

_____

Any surgeries within the last 6 months? Y N If so, explain.

_____

Any dermal injections/fillers with in the last 6 months? Y N If so, explain.

Continued >

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 or over the counter skin product? Y N

Have you used any of these products in the past 3 months? Y N If so, explain.

_____

Have you ever had any of the following treatments: (Please circle all that apply)
Facial Body Scrub Body Wrap Waxing Sugaring Microdermabrasion
Chemical Peel Laser Resurfacing Botox Injections Juvaderm fillers

Have you ever had any allergic reaction to any skin products? Y N If so, explain:

_____

Do you wear sunscreen daily? Y N

What temperature water do you cleanse your skin with? Cold Warm Hot

What type of skin care products do you use?

_____

Female Clients Only: Are you currently or trying to become pregnant? Y N

Are you currently lactating? Y N

Any recent changes to or from your contraceptive treatment Y N If so, explain

_____

Client Consent: I understand, have read and completed the questionnaire truthfully. I agree that this constitutes full disclosure, and that it supercedes 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 Essentials Spa and Wellness and/or skin care professional from any liability and assume full responsibility thereof.

Client Signature _____ Date:_____

Esthetician Signature _____Date:_____