CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? *Yes* ☐ *No* ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- ☐ Acne
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy
- ☐ Fever blisters
- ☐ Heart condition
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Hyper pigmentation
- ☐ Hypo pigmentation
- ☐ Hysterectomy
- ☐ Immune disorders
- ☐ Insomnia
- ☐ Keloid scarring
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Metal bone pins/plates
- ☐ Phlebitis, blood clots
- ☐ Seizure disorder
- ☐ Skin disease/lesions
- ☐ Seborrhea
- ☐ Thyroid condition
- ☐ Varicose veins
- ☐ Warts

Any other condition: _____

Notes:

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Any known allergies? ☐ No ☐ Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

_____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Have you ever had a facial treatment before? ☐ No ☐ Yes

If yes, please explain: _____

What would you like to achieve from your treatment today?

_____

SKIN CARE

Please Check Current Products You Use:

☐ Eye Make-Up Remover	☐ Eye Cream	☐ Mask
☐ Cleansing Cream	☐ Day Cream	☐ Facial Scrub
☐ Facial Soap	☐ Night Cream	☐ Exfoliants
☐ Skin Toner/ Astringent	☐ Neck lotion	☐ Body Lotion
☐ Body Soap	☐ Hand cream	☐ Body Scrub

SKIN HISTORY

What is your skin type?	☐ Normal	☐ Oily	☐ Dry	☐ Combo	☐ Unsure
Your exposure to the sun?		☐ Never	☐ Light	☐ Moderate	☐ Excessive
What type of foundation do you wear?		☐ Liquid	☐ Cream	☐ Powder	☐ None
How does your skin heal?		☐ Fast	☐ Slow	☐ Scars	☐ Pigments
Do you get bruises easily?		☐ No	☐ Yes		

SKIN CONCERNS

☐ Acne	☐ Dryness/Dull Skin	☐ Milia	☐ Sensitivity
☐ Blackheads	☐ Eczema	☐ Oily Skin	☐ Sun Damage
☐ Broken Capillaries	☐ Fine lines/Wrinkles	☐ Psoriasis	☐ Thin Skin
☐ Comedones	☐ Hyper pigmentation	☐ Redness	☐ Unwanted Hair
☐ Cherry Angioma	☐ Hypo pigmentation	☐ Rosacea	☐ Other:
☐ Discoloration	☐ Keloids	☐ Scarring	_____

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Have you ever used acne medication? ☐ No ☐ Yes

If yes, when? _____ Which drug? _____

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? ☐ No ☐ Yes, please describe: _____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

☐ No ☐ Yes, please describe: _____

By signing below, you agree to the following:
I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.

_____ _____

Esthetician (signature) *Client Name (signature)*

_____

Date

CLIENT CONSENT FORM

I hereby consent to and authorize _____ to perform the following procedure: _____ .

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by:

_____ .

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

By signing below I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injuiry or damages incurred due to any misrepresentation of my health.

This agreement will remain in effect for this procedure and all future follow-ups conducted by the technician. I understand that this consent agreement is legal and binding. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to the brow lamination procedure, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows:

_____

By his or her signature below, he or she ratifies and consents to this procedure under these terms.

_____ _____

Esthetician (signature) *Client Name (signature)*

_____

Date