Client Intake Form

Client Full Name: _____ Today's Date: _____
Mailing Address: _____
Email Address: _____
Cell Phone: _____ Preferred Method of Contact: Phone __ Text __ Email __
Date of Birth: _____ Employer:_____
Emergency Contact: _____ Phone Number: _____
How did you hear about us? _____

Medications
Please list any medications or supplements you are taking: _____
_____
Topical Medications: (ie. Hydroquinone, Renova, Retin-A, Differin, etc.) _____
_____

Personal Health History
Please list any and all allergies: _____
_____
Are you pregnant or planning to become pregnant? Yes ___ No ____
Are you currently taking birth control? Yes __ No __
Are you diabetic? Yes ___ No ___ Do you have or have you had cancer? Yes ___ No ____
Do you have metal implants? Yes __ No ___ Do you smoke? Yes __ No __
Please list any immune system disorders or physical illnesses: _____
_____
_____
Please list recent surgeries in the past five years: _____
_____
Are you currently under medical supervision? Yes __ No __ Explain: _____
Check any condition that applies to you:
Contagious Skin Condition __
Open Sores or Wounds __
Easy Bruising __
Recent Accident or Injury __
Recent Fracture or Surgery __
Artificial Joint __
Sprains/Strains __
Current Fever __
Swollen Glands __

Heart Condition __
High or Low Blood Pressure __
Circulatory Disorder __
Varicose Veins __
Phlebitis __
Deep Vein Thrombosis/Blood Clots __
Joint Disorder/Arthritis/Osteoarthritis ___
Epilepsy __
Headaches/Migraines __
Decreased Sensation __
Fibromyalgia __
TMJ __
Carpal Tunnel Sundrome __

Skin History

How would you describe your skin? Dry __ Oily __ Combination __ Mature __ Sun-Damaged __
Acne Grades 1 & 2 __ Acne Grades 3 & 4 __ Rosacea/Broken Capillaries __ Large Pore Size __
Scarring and/or Acne Scarring __ Discoloration __ Uneven Skintone __
Females: Do you suffer from hormonal hair growth on upper lip, chin and/or chest?
Yes __ No __
How often are you in the sun? Frequently __ Occasionally __ Rarely __
Have you or any member of your family had skin cancer? Yes __ No __
How often do you use sunscreen? Frequently __ Occasionally __ Rarely __
What is your skin tone? Very Fair __ Fair __ Medium __ Medium-Olive __ Dark __ Very Dark __

How often do you receive facials, chemical peels, microdermabrasion, cosmetic laser treatments, cosmetic injections? _____
Do you prefer extractions when you have a professional facial treatment? Yes __ No __
What is your daily skincare routine?
Daytime: _____
Evening: _____

_____ _____
Client Signature Today's Date

_____ _____
Student Service Provider Signature Today's Date

_____ _____
Licensed Instructor Signature Today's Date