



Client Intake Form

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Ph #: _____ Cell Ph #: _____ Work Ph #: _____

Email: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____ Referred By: _____

SKIN CARE

Which of the following best describes your skin type?

Very Oily Skin Large Pores Acne Dry Skin Sensitive Combination Normal

What is your daily skin care regimen? _____

How would you rate the overall quality of your skin?

Poor Fair Good Very Good

Are you currently using any topical medication (like Retin-A®) or exfoliating acids like salicylic or glycolic?

Yes No If yes, explain: _____

Are you currently using or have you used Accutane® in the past 12 months? Yes No

Do you wear contact lenses? Yes No Are you wearing them right now? Yes No

What improvements would you like to see to your skin? _____

SUN HISTORY AND LIFESTYLE

How often do you work outdoors? Frequently Occasionally Rarely

How often do you use sunscreen? Frequently Occasionally Rarely

How often do you tan or wear self-tanner? Frequently Occasionally Rarely

Client Intake Form (cont.)

MEDICAL HISTORY AND ALLERGIES

Please list all current medications, prescriptions, and homeopathic supplements: _____

Please list all allergies: _____

Do you have or have you ever had any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV or Other Immune Deficiency Disorders | <input type="checkbox"/> Herpes/Cold Sores |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hormone Imbalance | |

PREVIOUS PROCEDURES

Which of the following have you had in the last three months?

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> BOTOX® | <input type="checkbox"/> Radiesse | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Skin Rejuvenation |
| <input type="checkbox"/> Dysport® | <input type="checkbox"/> Restylane® | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Xeomin® | <input type="checkbox"/> Voluma® | <input type="checkbox"/> Permanent Makeup | <input type="checkbox"/> Facial Plastic/Reconstructive Surgery |
| <input type="checkbox"/> Fillers/JUVÉDERM® | <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Skin Resurfacing | <input type="checkbox"/> Other |

WOMEN ONLY: Are you pregnant or breastfeeding? Yes No

Are you interested in learning more about any of the following?

- | | |
|--|--|
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> PRP |
| <input type="checkbox"/> Fillers | <input type="checkbox"/> Specials/Packages |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Laser IPL | <input type="checkbox"/> Other |