DERMAPLANING
CLIENT INTAKE FORM

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

NAME:	AGE:	GENDER:
ADDRESS:	ZIP:	STATE:
EMAIL:	PHONE:	

Opt-in for email list to receive information & offers: ☐ Yes ☐ No

How did you hear about us? ☐ Friends/Family ☐ Social Media Other: _____

Skin Type: ☐ Oily ☐ Dry ☐ Combination ☐ Sensitive ☐ Reactive

What concerns you most about the overall appearance of your skin? (check all that apply)

- ◯ Acne
- ◯ Dehydrated Skin
- ◯ Dull Complexion
- ◯ Acne Scarring
- ◯ Excessive Facial Hair
- ◯ Facial Veins
- ◯ Age Spots
- ◯ Fine Lines/Wrinkles
- ◯ Large Pores
- ◯ Melasma
- ◯ Redness
- ◯ Broken Blood Vessels
- ◯ Oily Skin
- ◯ Bumps On Arms
- ◯ Rough/Uneven Skin Texture
- ◯ Rosacea
- ◯ Cysts/Nodules
- ◯ Sun Damage
- ◯ PIH
- ◯ Blackheads
- ◯ Whiteheads
- ◯ Frequent Breakouts

Other: _____

How would you describe your stress level? ☐ Low ☐ Moderate ☐ High ☐ Severe

GENERAL HEALTH:

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Any allergies? (Sulfa, food, iodine, medications, hay fever, latex) ☐ Yes ☐ No

If yes, please specify: _____

Are you currently taking any medications, herbs or vitamins? ☐ Yes ☐ No

If yes, please specify: _____

How many glasses of water do you consume daily? _____

When exposed to sun, do you: ☐ Burn Easily ☐ Tan Easily ☐ Never Burn ☐ Never Tan

What's your general health? _____

Are you prone to cold sores? ☐ Yes ☐ No If yes, date of last cold sore: _____

If yes, do you have a prescription for Valtrex or similar for prevention? ☐ Yes ☐ No

For women only: ☐ HRT ☐ Menopause ☐ Pregnant ☐ Birth Control Pills

Do any of the following apply to you? ☐ Smoker ☐ Wear Contacts

Please check if using any of the following:

- ☐ Hydroquinone
- ☐ Glycolic /Alpha Hydroxy Acid
- ☐ Retinoid (Vitamin A derivatives: Retin-A, Renova, Differin, Tazorac, Tretinon)
- ☐ Other: _____

Have you ever had any of the following?

- ☐ Botox Injections Date: _____
- ☐ Collegen Injections Date: _____
- ☐ Blepharoplasty (Eye Lift) Date: _____
- ☐ Rhytidectomy (Face Lift) Date: _____
- ☐ Restylane Injections Date: _____
- ☐ Laser Resurfacing Date: _____
- ☐ Rhinoplasty (Nose) Date: _____
- ☐ Skin Cancer Date: _____

Have you recently received any of the following?

- ☐ Face Treatment Date: _____
- ☐ Chemical Peel Date: _____
- ☐ Laser/IPL Date: _____
- ☐ Microneedling Date: _____
- ☐ Ultherapy Date: _____

Please check the skincare products you are currently using:

☐ Cleanser ☐ Eye Cream ☐ Scrub ☐ Serum ☐ Mask ☐ Toner

☐ Moisturizer ☐ Self Tanner ☐ Retinol ☐ Concealer

Other: _____

I have read the above information. I have accurately answered the questions above, including all known allergies, medications, or products I am currently ingesting or using topically. I give permission to my skin therapist to perform the dermaplaning treatment we have discussed and will hold him/her and his/ her staff harmless from any liability that may result from this treatment. I understand the procedure and accept the risks. I do not hold the skin therapist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, that may be affected by the treatment performed today.

Client Name (Printed)	Client Signature	Date
Skin Therapist Name (Printed)	Skin Therapist Signature	Date

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CLIENT CONSENT FORM

Although every precaution will be taken to ensure your safety and wellbeing before, during, and after your dermaplaning treatment, please be aware of the following information and possible risks.

Please Initial:

_____ I understand that dermaplaning is the process of removing superficial layers of dead skin cells on the skin's surface by the use of a sterileblade.

_____ I have been explained the process of dermaplaning by my Aesthetician and have had the opportunity to ask any questions.

_____ I understand that results may not be seen in a single treatment. The ideal plan of treatment is to have at least one dermaplaning treatment as directed by my Aesthetician to enhance any skin conditions and follow up with maintenance treatments as needed.

_____ I understand, for optimum results, the importance of following the pre-prep home care system as well as the post-home care system recommended to me by my Aesthetician.

_____ I understand that there may be unforeseen risk with dermaplaning such as cutting, scraping, or abrading the skin with the blade.

_____ I am satisfied with the information provided to me regarding dermaplaning and agree to have the procedure performed on me.

_____ I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur.

_____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

_____ I am over 18 years of age or have parental consent form signed and attached.

_____ I have read and completed this consent form in its entirety, and have answered everything to the best of my ability.

I have read the contents of this consent form carefully, and I fully understand it. I have been given the opportunity for discussion pertaining to Dermaplaning treatments and all my questions have been answered to my satisfaction. I hereby **AZ Med SPA** and any of its employees against any and all liability associated with this procedure. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the Dermaplaning treatment.

By signing below, I verify that I have read and understand the above statements and agree to them.

Client Name (Printed) _____

Client Signature _____

Date _____