FACIAL
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: ____________________

What are your long-term skin goals? ____________________

What are your areas of concern? ____________________

What are your goals from today's treatment? ____________________

Have you ever had professional skin care treatments previously? ☐ Yes ☐ No

If yes, please explain: ____________________

Do you wear contact lenses? ☐ Yes ☐ No

What skin care products do you use presently? ____________________

Exposure to sun? ☐ Light ☐ Moderate ☐ Excessive

MEDICAL INFORMATION:

Are you presently using (or used in the past) Azlex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alpha Hydroxy Acids? ☐ Yes ☐ No

If yes, when and for how long? ____________________

Are you now using or have you ever used Accutane? ☐ Yes ☐ No

Please list any allergies you have: ____________________
(including cosmetics or Ingredients)

List all medications you are taking: ____________________
(including OTC drugs, vitamins etc.)

Have you had skin cancer? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

Have you ever had any of these conditions ? If NONE apply, please tick ☐ here:

Asthma ☐	Herpes Simplex ☐	Citrus Allergy ☐	Rosacea ☐	Autoimmune ☐	Eczema ☐	Hysterectomy ☐
Arthritis ☐	Cancer/Chemo ☐	Eye Infections ☐	Migraines ☐	Heart Disease ☐	Psoriasis ☐	Pregnancy ☐
Facial Warts ☐	MRSA ☐	Sulfur Allergy ☐	Sun Burn ☐	Sciatica ☐	Skin Disease ☐	Watery eyes ☐

Any other: ____________________

I have read the above information and have given an accurate account of the questions. If I have any concerns, I will address these with my esthetician before the service. I understand that the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature. I give permission to my esthetician to perform the facial service and will not hold the esthetician nor **[Business Name]** accountable for any liability that may result from this treatment. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

____________________ ____________________ ____________________
Client Name Client Signature Date:

____________________ ____________________ ____________________
Esthetician Name Esthetician Signature Date:

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SKIN CARE HISTORY:

Select your skin type: ☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Acne Prone ☐ T-Zone

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

If yes, when? ____________________

Have you ever had chemical peels, laser or microdermabrasion? ☐ Yes ☐ No

If yes, when and how long? ____________________

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? ☐ Yes ☐ No

If yes, please explain: ____________________

Have you used any of these products in the last 3 months? ☐ Yes ☐ No

Do you ever experience oily shine during the day? ☐ Yes ☐ No

Do you ever experience a burning, itching sensation on your skin? ☐ Yes ☐ No

Have you used an acne medication? ☐ Yes ☐ No

If yes, when and which drug? ____________________

Do you ever experience a reaction to any of the following?

☐ Cosmetics ☐ Iodine ☐ Pollen ☐ Medicine

☐ Hydroxyl acids ☐ Fragrance ☐ Sunscreens ☐ Animals

Other: ____________________

Any recent tanning bed or sun exposure that changed the color of your skin? ☐ Yes ☐ No

Have you experienced Botox, Restylane or Collagen injections? ☐ Yes ☐ No

If yes, please explain: ____________________

What concerns do you have with your skin?

☐ Discoloration ☐ Breakouts/acne ☐ Redness ☐ Dark Circles

☐ Uneven Skin Tone ☐ Wrinkles ☐ Rosacea ☐ Whiteheads

☐ Oily Skin ☐ Fine Line ☐ Broken Capillaries ☐ Blackheads

☐ Dry, Flaky Skin ☐ Dull Skin ☐ Enlarged Pores ☐ Sun Spot/

☐ Acne/Breakouts ☐ Sun damage ☐ Lax or Sagging Skin ☐ Cellulite

Explain your skin goals in detail: ____________________

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HEALTH HISTORY:

Are you currently under a dermatologist or other physician's care? ☐ Yes ☐ No

If yes, please explain: ______________________

Within the last one year, have you been undergone any surgeries? ☐ Yes ☐ No

If yes, please explain: ______________________

Do you wear contact lenses? ☐ Yes ☐ No

Tick any of the following that apply to you. Please check here ◯ if none apply.

- ◯ Hypertension
- ◯ Skin Disease
- ◯ Transplant(s)
- ◯ Acute Inflammation
- ◯ Melanoma
- ◯ Cancer/Tumor
- ◯ Infectious Disease
- ◯ Joint Replacement(s)
- ◯ Blood Clots
- ◯ Numbness
- ◯ Metal Implants
- ◯ Kidney Disease
- ◯ Communicable Disease
- ◯ Neurological Disorder
- ◯ Cardiovascular Conditions
- ◯ Diabetes
- ◯ Organ Failure
- ◯ Heart Disease
- ◯ Liver Disease
- ◯ Unhealed wounds
- ◯ Epilepsy
- ◯ Pacemaker/Other Electronic Device

Explain any conditions you have marked above:

____

FOR FEMALE CLIENTS:

Are you taking any birth control pills?? ☐ Yes ☐ No

If yes, please specify: ______________________

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Any menopause problems? ☐ Yes ☐ No

If yes, please explain: ______________________

Are you on hormone-replacement therapy? ☐ Yes ☐ No

If yes, please explain: ______________________

Is there anything else that should be known before starting your treatment?:

____

FOR MALE CLIENTS:

What is your current shaving system? ☐ Wet Shave ☐ Electric

Do you experience irritation from shaving? ☐ Yes ☐ No

Is there anything else that should be known before starting your treatment?:

____

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Client Name	Client Signature	Date:
Esthetician Name	Esthetician Signature	Date:

FACIAL
CLIENT CONSENT FORM

I ________________________________ hereby consent to and authorize **AZ Med SPA** to perform the following procedure: ____

____

Please Initial:

___ I have voluntarily elected 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.

___ 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 on 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 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 office immediately.

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

___ I 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 office immediately.

___ I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

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

Client Name (Printed)	Client Signature	Date