MICRODERMABRASION
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 microdermabrasion 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

MICRODERMABRASION
CLIENT CONSENT FORM

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

Please Initial:

____ I understand that microdermabrasion is an elective skin rejuvenation treatment intended to remove superficial surface layers of the skin to improve tone, texture, and clarity.

____ I have been informed of alternative treatments, which include: chemical peels, intense pulsed light (IPL), skin care products or no treatment at all.

____ I understand that the result of a one-time treatment is similar to a deep cleansing or polishing of the skin. I understand that in order to see significant results, these treatments need to be done in a series and in combination with using active ingredient skin care products.

____ I acknowledge that after my microdermabrasion procedure, treated areas may feel warm and appear sunburned; or my skin may experience a wind-burned sensation.

____ I understand that no specific guarantees can or have been made concerning the expected results.

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

____ I understand that compliance to my post-care instructions will greatly affect my final result. I acknowledge my obligation to follow the written and spoken instructions covering my pre and post-treatment skin care regimen.

____ I understand that although rare, certain risks or complications could occur; but are usually treatable and temporary, such as hyperpigmentation, hypo-pigmentation, and scarring. Following all post procedure instructions will help avoid these conditions.

____ I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for an anti-viral (Valtrex) prior to having microdermabrasion. I understand that I need to avoid treatments during a breakout

____ I acknowledge that I have not used Accutane during the last 12 months.

____ I acknowledge that I have not had dermal fillers or other injectables in the treated area 10 days to 14 days in the past 10 – 14 days.

____ I acknowledge that I should avoid the use of alpha-hydroxy acids, beta hydroxy acids and Retinol products 1 week prior to and following treatment.

____ 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 Microdermabrasion 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 Microdermabrasion 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 _____