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| Facial Client Intake Form | | | | | | | | |
| **Personal Information** | | | | | | | | |
| Name: | | |  | |  | |  | |
| Address: | | |  | | | | | |
| City: | | |  | State: |  | | | Zip: |
| Cell Phone: | | |  | Cell Phone Carrier: | | |  | |
| DOB: | | |  | Email: |  | | | |
| **History** | | | | | | | | |
| Do you have any health problems or concerns that we need to be aware of before treatment? If yes, please describe. | | | | | | | | |
|  | | | | | | | | |
| What are you skin concerns and challenges? | | | | | | | | |
|  | | | | | | | | |
| Do you have any allergies we should be aware of? If yes, please describe. | | | | | | | | |
|  | | | | | | | | |
| Are you currently under a physician’s care for any skin condition? If yes, please describe. | | | | | | | | |
|  | | | | | | | | |
| Have you ever had an adverse reaction to a cosmetic product or ingredient? If yes, please describe. | | | | | | | | |
|  | | | | | | | | |
| Have you ever had an adverse reaction to a skin care treatment? If yes, please describe. | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Please check the box next to any of that items that apply to you.** | | | | | | | | |
|  | | | | | | | | |
|  |  | Currently wearing contact lenses | | |  | Pregnant (Due Date: \_\_\_\_\_\_\_\_\_\_\_\_) | | |
|  | | | | | | | | |
|  |  | Pacemakers/Pins in Bones | | |  | Recent surgery on face, neck, and/or shoulders | | |
|  | | | | | | | | |
|  |  | Had a chemical peel in the last 6 months | | |  | Currently taking Accutane or in the last year | | |
|  | | | | | | | | |
|  |  | Are you currently, or have you used Retin-A/Renova, or any alpha-hydroxy acids within the past 3 months? | | | | | | |
| High frequency should not be used on clients with the following conditions: couperose skin, inflamed areas, pacemakers, heart problems, high blood pressure, braces, epilepsy, and/or pregnant.  Please check here if you have any of the conditions listed in the sentence above. \_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Current Skin Care Information** | | | | | | | | |
| What products are you currently using on your skin?  Daytime: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Evening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Describe any weekly/special treatments. | | | | | | | | |
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|  |  |  |
| Client Signature (Or parent/guardian if applicable) |  | Date |

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| --- | --- | --- |
|  |  |  |
| Therapist Signature |  | Date |