Facial Intake Form

Appointment date

Appointment time

Personal Information

FULL NAME

D.O.B.

AGE

PHONE #

ADDRESS

EMAIL / NEWSLETTER

Would you like to be added to our subscriber list in order to receive information about upcoming discounts, promotions, contests etc.?

- ◯ YES! Sign me up!
- ◯ No, thanks

General Information

Exposure to the sun:

- ☐ Never
- ☐ Moderate
- ☐ Light
- ☐ Excessive

How do you prefer to get a skin tone?

- ☐ Sunbath
- ☐ Self-tanning
- ☐ Tanning bed
- ☐ Nothing

How would you describe your skin?

- ☐ Normal to dry
- ☐ Normal to oily
- ☐ Extremely oily
- ☐ Extremely dry
- ☐ Acne
- ☐ Combination

Do you experience:

- ☐ Flakiness
- ☐ Redness
- ☐ Tightness
- ☐ Excessive oily shine during the day

What type of foundation do you wear?

- ☐ Liquid
- ☐ Cream
- ☐ Powder
- ☐ None

How does your skin heal?

- ☐ Fast
- ☐ Scars
- ☐ Pigments
- ☐ Heals poorly

Do you bruise easily?

- ☐ Yes
- ☐ No

Any personal or family history of cancer?

- ☐ Yes
- ☐ No

Do you take care of your skin at home?

- ☐ Yes
- ☐ No

Please, describe

Is it your first skin care treatment?

- ☐ Yes
- ☐ No

What have you liked about previous treatment?

Do you smoke?

- ☐ Yes
- ☐ No

What is your daily amount

Do you have any from listed below:

- ☐ Epilepsy
- ☐ Recent operations
- ☐ Heart condition
- ☐
- ☐ Diabetes
- ☐ Skin cancer
- ☐ Allergy to aspirin
- ☐ Skin diseases

Have you used Accutane in the past 12 months?

☐ Yes ☐ No

Have you used Retin- A in the past month?

☐ Yes ☐ No

Have you used any oral/ topical skin medications in the past 6 months?

☐ Yes ☐ No

If yes, please, describe

Do you have allergies to latex?

☐ Yes ☐ No

Do you have allergies to any skin care products?

☐ Yes ☐ No

If yes, please, describe

Are you currently on any medications?

☐ Yes ☐ No

If yes, please, describe

Women only

Are you:

☐ Pregnant
☐ Trying to become pregnant
☐ Not pregnant
☐ Taking oral contraceptives
☐ Taking hormone replacements

Men only

Do you suffer from ingrown facial hair?

☐ Yes ☐ No

Experience razor burn?

☐ Yes ☐ No

Please, check the box if you are affected by or having any of the following:

☐asthma	☐skin disease	☐eczema	☐pins or plates
☐fever blisters	☐immune disorders	☐herpes	☐headaches-chronic
☐hysterectomy	☐depression	☐high blood pressure	☐lupus
☐sinus problems	☐anxiety	☐epilepsy	☐metal bone
☐cardiac problems	☐hepatitis	☐pace maker	

How would you describe your overall health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever had reaction to:

☐ Cosmetics ☐ Fragrance ☐ Medication ☐ Other

This form is completely confidential. Completion of form gives the general state of health and assists our specialist in directing a customized course of treatment for you.
The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose any any existing or past health conditions.

Patient Name Date

Technician Name Date

Skin Care Consultation Form

Personal Information

FULL NAME

D.O.B. AGE PHONE # EMAIL

ADDRESS CITY STATE

Lifestyle:

☐ Active ☐ Sedentary

Any cosmetic surgery/non-surgery:

What? When?

SKIN ANALYSIS

Skin type:

☐ Normal ☐ Dry

☐ Combination ☐ Oily

Skin sensitivity:

☐ Normal ☐ Sensitive

☐ Hypersensitive

Lines:

☐ Fine lines ☐ None

☐ Wrinkles in motion

Acne:

☐ No

☐ Yes

☐ I ☐ II ☐ III ☐ IV

Pores:

☐ Fine ☐ Dilated

☐ Comedones ☐ Milia

MEDICATIONS

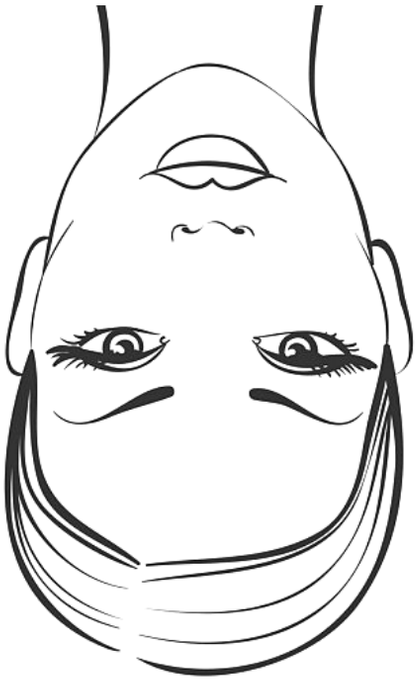
List medications in the last 30 days (pills, birth control, vitamins, herbal supplies, etc.):

ALLERGIES

Reaction allergies:

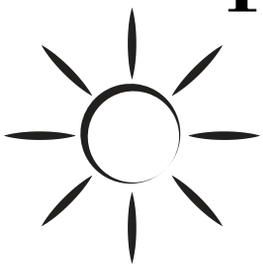
Skin allergies:

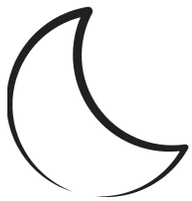
Products used:



TREATMENT PLAN

Client After-Treatment Perfect Routine





CLEANSER	Step 1	**CLEANSER**
TONER	Step 2	**TONER**
ANTIOXIDANT SERUM	Step 3	**TREATMENT**
EYE CREAM	Step 4	**EYE CREAM**
ACNE SPOT TREATMENT	Step 5	**MOISTURIZER**
MOISTURIZER	Step 6	
SUNSCREEN	Step 7	