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

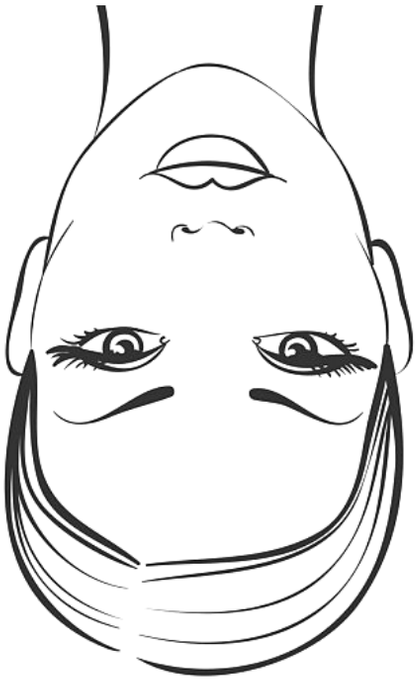
List medications in the last 30 days (pills, birth control, vitamins, herbal supplies, etc.):

ALLERGIES

Reaction allergies:

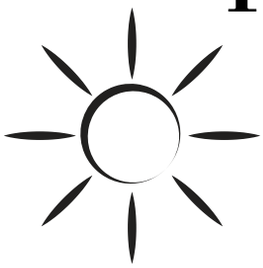
Skin allergies:

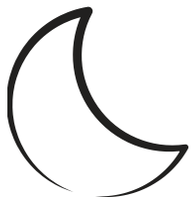
Products used:



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	

APPOINTMENT CANCELLATION POLICY

Dear Client,

We strive to render excellent care to you and the rest of our clients. Your care and treatment is a priority for us. We also ask that you respect your specialist's time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our clients, with respect for your time, the next client's time, and the specialist's time.

Our policy is as follows:

We request that you give a notice **not later than 24 hours** prior your scheduled appointment in the event that you can not make it. If the client misses an appointment without contacting us, it is considered a missed or "No Show" appointment. Additionally, if a client is more than 15 minutes late for an appointment, it will be considered as " No Show" appointment, and that appointment will be rescheduled. Also, if you miss more than 3 (three) appointments, we reserve the right to charge you a fee of $_____.

A $_____ non refundable deposit will be paid at time of making appointment and will be taken off at the time of the appointment.

If you have questions regarding this policy, please let us know, and we will be happy to clarify our policy for you.

I have read and understand the Appointment Cancellation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to this terms.

I, ... , have received the copy of Cancellation Policy.

CREDIT CARD	NUMBER	EXP. DATE	CVV

Client Signature . . . . . .

Receptionist Signature . . . . . .

Date . . . . . .

Consent Form

I hereby consent to and authorize _____ (esthetician) to perform the following procedure: _____

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, by _____ (esthetician)

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 upon 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 have read and 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 esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

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.

Client name .....

Client signature ..... Date .....

Esthetician name ..... Date .....