Facial Client Consultation & Skin Intake Form

Please Print Legibly

Name ______________________________ DOB ______________

Address ______________________ City ______________ State ______ Zip __________

Email ______________________________ Phone ______________________

Cell Phone Service Provider (if you want to receive text messages) Circle one: AT & T T- Mobile Verizon Other ____________

Please take a moment to carefully read the following information and sign where indicated.

Have you ever had a professional facial treatment before? Yes ☐No How recently? ______________

What are your goals? ______________________________

List current medications: ______________________________

Do you have diabetes? Yes ☐ No Do you have cardiac/circulatory problems? ☐ Yes ☐ No

Vhich of the following best describes your skin type? (Please circle one type number.)

I	Creamy complexion	Always burns easily, never tans
II	Light complexion	Always burns, tans slightly
III	Light/Matte complexion	Burns moderately, tans gradually
IV	Matte complexion	Seldom burns, always tans well
V	Brown complexion	Rarely burns, deep tan
VI	Black complexion	Never burns, deeply pigmented

Have you ever had chemical peels, laser, or microdermabrasion? ☐ Yes ☐ No Within the last month? ☐ Yes ☐ No

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Accutane, or Retinol/Vitamin A derivative product? ☐ Yes ☐ No

Have you experienced Botox, Restylane, or Collagen injections? ☐ Yes ☐ No If yes, explain: ______________

Have you used any of the above-mentioned products in the last 3 months? ☐ Yes ☐ No

Have you used an acne medication? ☐ Yes ☐ No If yes, please specify: ______________

Have you had any allergic reactions to the following? If yes, check and explain:

____

☐ Cosmetics ☐ Sunscreens ☐ Latex

☐ Medicine ☐ Fragrance ☐ Shellfish / Iodine

☐ Food ☐ Alpha Hydroxy Acids ☐ Drugs

☐ Animals ☐ Pollen ☐ Other: ______________

What skin care products do you use? Please list the brand when know.

☐ Soap/Cleanser __________ ☐ Eye Product __________ ☐ Night Moisturizer/Cream __________

☐ Exfoliator/Scrub __________ ☐ Day Moisturizer __________ ☐ Other: __________

☐ Mask __________ ☐ Sunscreen __________ ☐ __________

☐ Toner __________ ☐ SPF? __________ ☐ __________

What areas of concern do you have regarding your skin? Please check all that apply.

Breakouts/Acne ☐ Broken capillaries ☐ Sun damage

❐ Blackheads/Whiteheads ☐ Redness/ruddiness ☐ Wrinkles/fine lines

Excessive oil/shine ☐ Sun spot/liver spot/brown spot ☐ Dull/dry skin

❐ Rosacea ☐ Uneven skin tone ☐ Other: ______________

☐ Flaky skin ☐ Dehydrated skin ______________

I understand, I have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: ______________________ Date: ______________

Practitioner Signature: ______________________ Date: ______________

Consent to Treatment of Minor: By my signature, I hereby authorize the practitioner to administer esthetic services to my child or dependent, as they deem necessary.

Signature of Client or Guardian: ______________________ Date: ______________

Recommendations

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