Esthetics Intake and Treatment Consent

Client Name ____ Gender __M __F __Other DOB __________________

Preferred contact number ________________________________ Email ____
May we leave a message if we do not reach you personally? ___Y ___N

What are your top 3 skin concerns?
1. ____

2. ____

3. ____

Medical History: Pregnant? __Yes __ No Breastfeeding? __ Yes __ No
Do you smoke? __Yes __No
Health Conditions ____
Past Surgeries ____
Have you ever been diagnosed with Cancer? __Yes __ No (last treatment date) __________________
Current Medications ____
Prescription Topicals ____
Allergies (include aspirin & iodine) ____

Previous Treatments:

Facials	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Dermabrasion	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Chemical Peels	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Injectibles	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Waxing	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Tanning	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Laser Therapy	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Light Therapy	__Yes __ No	Last treatment:_____________	Any Complications? ____________________
Massage	__Yes __ No	Last treatment:_____________	Any Complications? ____________________

Skin Conditions: *(please check all the items below that pertain to you)*

__ Skin Infection	__ Herpes (cold sores)	__ Keloids/Excessive Scarring	__ Skin Cancer
__ Poor Healing	__ Tattoos/Permanent Makeup	__ Eczema	__ Psoriasis
__ Lymph Nodes Removed	__ Sun Sensitivity	__Easy Bruising	__ Auto Immune Condition

Skincare: What type of skin do you feel you have? __ Dry __ Oily __ Normal __ Combination

What is your skin routine? (indicate any cleansers, toners, serums, moisturizers, masques, etc.)

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

Treatment Constent

Client Name ____ Date __________________________

- I agree that the nature and purpose of the treatment has been explained to me, and any questions I have regarding the treatment have been explained to my satisfaction.
- I understand that any treatment at Inis Spa is not a substitute for a medical examination or treatment. I should see a physician or other qualified health specialist for any mental or physical ailment I am aware of. I understand that practitioners at Inis Spa do not diagnose illness or disease, and nothing said during treatment should be construed as such.
- I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.
- I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores, or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.
- I do not have active cold sores.
- I will call to inform my skincare professional of any complications or concerns I may have as soon as they occur.
- I understand that it is recommended before having a facial infusion to not have used Retin A for 48 hours, Accutane in 6 months, or have waxed 24 hours before receiving treatment.
- I understand that this form will remain active for all future appointments. Any changes to the information provided will be recorded by my skincare professional. I understand that I may request to fill out a new form at any time.

Understanding all of this, I give my consent to receive care.

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Client Signature Print Name Date