

**Client Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check all that apply:

* Are you pregnant?
* Are you trying to get pregnant?
* Are you breastfeeding?
* Do you have an allergy to shellfish?
* Do you have any other allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you use an EPI Pen?
* Do you have metal implants?
* Do you have any heart problems?
* Do you have a pacemaker?
* Do you have high/low blood pressure?
* Do you have Epilepsy or a seizure disorder?
* Have you had any recent chemotherapy or radiation?
* Do you smoke?
* Are you currently under a Doctor’s care?
* Please list all past surgeries if any:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Please list all of your current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your skin care regimen?

\_\_\_Soap \_\_\_Cleanser \_\_\_Toner \_\_\_Exfoliator \_\_\_Mask \_\_\_Serum \_\_\_Moisturizer \_\_\_Sunscreen

Do you use any products that contain any of the following ingredients?

\_\_\_Retinoid (Vit A) \_\_\_Glycolic Acid \_\_\_Alpha Hydroxy Acid \_\_\_Salicylic Acid \_\_\_Lactic Acid

\_\_\_Accutane (or other acne drug) \_\_\_Benzoyl Peroxide Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following skin issues? (Please check all that apply)

* Rosacea Psoriasis Skin Infection Diabetes
* Dermatitis Recent Sunburn Skin Cancer Easy Bruising
* Eczema Sun Sensitivity Lymph Nodes Removed Poor Healing

What is your stress level (1-5, 5 being very stressful)? \_\_\_\_\_\_

Have you ever experienced any of the following (date of last procedure)?

Microdermabrasion \_\_\_\_\_\_\_ Electrolysis \_\_\_\_\_\_\_\_ Waxing \_\_\_\_\_\_\_ Chemical Peel \_\_\_\_\_\_\_\_ Laser \_\_\_\_\_\_\_\_ Depilatories \_\_\_\_\_\_\_\_ Injectables \_\_\_\_\_\_\_\_ Botox \_\_\_\_\_\_\_\_ Tanning\_\_\_\_\_\_\_\_



**Consent for Treatment**

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the treatment may be adjusted to my comfort. I further understand that facial treatments should not be construed as a substitute for medical examination or diagnosis. I affirm that I have stated all my known medical conditions and answered all questions honestly and understand that there shall be no liability on the practitioner’s part should I fail to do so. Understanding all of this, I give my consent to receive care.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please initial the following statements and sign below:

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 understand that it is recommended prior to having a facial infusion to not have used Retin-A for 72 hours, Accutane in 6 months or have waxed 24 hours prior to receiving treatment.

Client Signature: Date:

Print Name:

**For Esthetics Use Only**

**Esthetics Intake**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notes:

Retin-A: Y N Daily H2O: \_\_\_\_\_\_ Currently Pregnant (weeks) or trying?\_\_\_\_\_\_\_\_\_\_\_\_

Taking Medications or under Physicians care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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