Confidential Client Intake Form

**Personal Information**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Last, First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth (MM/DD/YYYY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your job require that you work outdoors: (check one) Yes No

Emergency contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Visit:**

Briefly describe the reason for your visit today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What are you hoping to achieve from your visit today:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin History:**

Have you visited a dermatologist in the past year: (check one) Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any known skin conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you ever experience: (check all that apply)

|  |  |
| --- | --- |
|  Skin breakouts   Oily shine throughout the day   A burning, itching sensation on your skin   Flakiness and/or tightness   Blush easily when nervous |  Tendency to redness   Sinus problems   Claustrophobia   Bothered by scents, oils, or lotions |
| Have you ever used an acne medication: (check one) | Yes No If yes, which one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

How would you rate the overall quality of your skin: (check one)

 Poor

 Fair

 Good

 Very good

 Excellent

Any questions/concerns you have with your skin: (check all that apply)

|  |  |
| --- | --- |
|  Breakouts/acne  Uneven/loss of skin tone   Blackheads/whiteheads  Pigmentation   Excessive oil/shine  Discoloration   Large pore size  Sun/liver/brown spots   Redness/ruddiness  Sun damage   Rosacea  Wrinkles/fine lines   Broken capillaries/veins  Dull/dry skin  Have you ever had: (check all that apply) |  Flaky skin   Dehydrated   Unwanted hair   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Chemical peels  Facial treatment   Laser  Body/spa treatment   Microdermabrasion  Injections |  Botox   Collagen (fillers)   Permanent makeup |

If any checked, when was the last time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used any of these hair removal methods in the past six weeks: (check all that apply)

|  |  |  |
| --- | --- | --- |
|  Shaving   Waxing   Electrolysis |  Plucking   Tweezing   Stringing |  Depilatories   Other: \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Which best describes your skin type: (check one)

 Creamy complexion, always burns easily, never tans

 Light complexion, always burns, tans slightly

 Light/matte complexion, burns moderately, tans gradually

 Matte complexion seldom, burns, always tans well

 Brown complexion, rarely burns, deep tan

 Black complexion, never burns, deeply pigmented

Have you been exposed to the sun/tanning bed within the last 48 hours: (check one) Yes No

Do you sunbathe or use tanning beds: (check one) Yes No

Have you recently used any self-tanning lotions, creams, or treatments: (check one) Yes No

Do you wear SPF on your face: (check one) Yes No If yes, which one: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which skin care products are you currently using? (check all that apply, fill in brand)

|  |  |
| --- | --- |
|  Soap: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Toner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Mask: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Eye Product: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Cleanser: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Day Moisturizer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Exfoliator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Scrubs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Shower Gels: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Body Lotions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Sunscreen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   SPF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Night Moisturizer/Cream: \_\_\_\_\_\_\_\_\_\_\_   Makeup Products: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Have you ever experienced a reaction to any skin care products: (check one) Yes No

If yes, which ones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced allergic reaction to the following: (check all that apply, if so, explain)

|  |  |
| --- | --- |
|  Cosmetics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Medicine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Sunscreens: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Iodine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  AHAs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Fragrance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Shellfish: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Latex: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medical History**

Current medications/vitamins: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Allergies: (check all that apply)

|  |  |  |
| --- | --- | --- |
|  Aspirin or salicylates   Milk  Citrus   Grapes |  Lavender   Fish, marine, or iodine  allergies   Cosmetic products |  Skin care products   Nuts/peanuts   Medications   Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

If any checked, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Past or present, have you ever had any of the following health conditions: (check all that apply)

|  |  |  |
| --- | --- | --- |
|  Cancer   Headaches   Hormone imbalance   Hepatitis   High/low blood pressure   Fever blisters/cold sores   Hysterectomy   Immune disorders |  Spinal injury   HIV/aids   Diabetes   Poor circulation   Heart problems   Insomnia   Varicose veins   Skin diseases/lesions |  Arthritis   Asthma   Any active infections   Eczema   Epilepsy   Scar easily   Surgery/ plastic surgery |

If any checked, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you smoke: (check one) Yes No

Do you exercise regularly: (check one) Yes No

How many glasses/cups of water do you drink daily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you follow a restricted diet: (check one) Yes No

On a scale of 1-10, with 10 being high, what is your stress level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses: (check one) Yes No

Do you have metal implants, a pacemaker, or body piercings: (check one) Yes No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEMALES ONLY

Are you taking any oral contraceptives: (check one) Yes No

Are you pregnant or trying to become pregnant: (check one) Yes No

What is the date of your last menstrual cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing any menopause problems: (check one) Yes No

Are you undergoing any hormone replacement therapy: (check one) Yes No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MALES ONLY

What is your current shaving system: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience irritation from shaving: (check one) Yes No

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ingrown hairs: (check one) Yes No

**Contact Preference and Photo Consent**

To be reached about future appointments, the following may be used: (check all that apply)

 Home phone  Cell phone  E-mail

 Work phone  Text

Can we contact you via mail/e-mail about future promotions and news: (check one) Yes No

I consent to photos being used for office use: (check one)No

Yes

Yes

I consent to photos being used for advertising: (check one)No

How did you hear about us: (check any that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|      | Internet search  Website  Friend/family member |      | Newspaper  Ad  Social media |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I understand, have read, and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history. 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 name (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Update** (for future appointments):

I have reviewed my confidential intake form and the above information is still correct and any changes have otherwise been indicated on this form.

Client name (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature (or legal guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_