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: _____

☐ Single ☐ Married (check one) 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	Tendency to redness
Oily shine throughout the day	Sinus problems
A burning, itching sensation on your skin	Claustrophobia
Flakiness and/or tightness	Bothered by scents, oils, or lotions
Blush easily when nervous	

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	Flaky skin
Blackheads/whiteheads	Pigmentation	Dehydrated
Excessive oil/shine	Discoloration	Unwanted hair
Large pore size	Sun/liver/brown spots	Other: _____
Redness/ruddiness	Sun damage	_____
Rosacea	Wrinkles/fine lines	_____
Broken capillaries/veins	Dull/dry skin	_____

Have you ever had: (check all that apply)

Chemical peels	Facial treatment	Botox
Laser	Body/spa treatment	Collagen (fillers)
Microdermabrasion	Injections	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	Plucking	Depilatories
Waxing	Tweezing	Other: _____
Electrolysis	Stringing	_____

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: _____	Cleanser: _____
Toner: _____	Day Moisturizer: _____
Mask: _____	Exfoliator: _____
Eye Product: _____	Scrubs: _____

Shower Gels: _____ Night Moisturizer/Cream: _____

Body Lotions: _____ Makeup Products: _____

Sunscreen: _____ Other: _____

SPF: _____ _____

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: _____ AHAs: _____

Medicine: _____ Fragrance: _____

Food: _____ Shellfish: _____

Sunscreens: _____ Latex: _____

Iodine: _____ Other: _____

Medical History

Current medications/vitamins: _____

_____

_____

Allergies: (check all that apply)

Aspirin or salicylates	Lavender	Skin care products
Milk	Fish, marine, or iodine	Nuts/peanuts
Citrus	allergies	Medications
Grapes	Cosmetic products	Other: _____

If any checked, explain: _____

_____

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

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

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) ☐ Yes ☐ No

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

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

Internet search	Newspaper	Other: _____
Website	Ad	_____
Friend/family member	Social media	_____

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: _____