FACELINE AESTHETICS

CLIENT INTAKE FORM

Name:_____ Date:_____/_____/_____

Email (**Please Print**) _____

☐ I want to receive promotions and communications through email.

Address: _____ City:_____State:_____Zip: _____

Home Phone: _____ Cell:_____ Work Phone: _____

Date of Birth:_____/_____/_____ Employer: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Medications

Please list any **medications or supplements (aspirin, herbals, fish oil, etc.)** you are taking:

_____

☐ Retin-A ☐ Differin
☐ Hydroquinone ☐ Renova
☐ Other skin care medications/topical agents: _____
☐ Accutane (current or within the past 6 months?)

Allergies

Please list any medication allergies: _____

Are you allergic to Latex? ☐Yes ☐No
Are you allergic to Iodine? ☐Yes ☐No

Are you currently pregnant or planning on becoming pregnant? ☐ Yes ☐ No Are you currently nursing ☐ Yes ☐ No

Please check all that apply to you:

☐Alcoholism
☐Anemia
☐Anorexia
☐Asthma
☐Autoimmune Disease
☐Fibromyalgia
☐Hepatitis A, B, or C
☐Herpes/Cold Sores
☐HIV/ Aids
☐History of Keloid Scarring
☐Bleeding Disorder
☐Breast Lump
☐Cancer
☐Connective tissue disorder
☐Chemical Dependency
☐Migraines
☐Multiple Sclerosis
☐Neuromuscular Disorder
☐Pacemaker of Defibrillator
☐Polycystic Ovaries
☐Chronic Fatigue
☐Diabetes
☐Eating Disorders
☐Epilepsy
☐Pigmentation Disorder
☐Seizures
☐Skin Lesion

FACELINE AESTHETICS

SKIN CARE

What is your daily skin care regimen?

_____

SUN HISTORY & LIFESTYLE

How often do you work outdoors? ☐ Frequently ☐ Occasionally ☐ Very Rarely

Have you or any member of your family had skin cancer? ☐ Yes ☐ No If yes, please explain: _____

How often do you use a sunscreen? ☐ Frequently ☐ Occasionally ☐ Very Rarely

How often do you use tanning beds? ☐ Frequently ☐ Occasionally ☐ Very Rarely

Which of the following best describes your skin type?

☐ Very oily skin, large pores
☐ Dry skin
☐ Oily skin
☐ Combination skin, oily in T-zone, dry to normal cheeks
☐ Sensitive skin

CONCERNS / INTERESTS:

☐ Unwanted hair Area: _____
☐ Acne
☐ Rosacea
☐ Dryness
☐ Fine lines
☐ Wrinkles
☐ Large pore size
☐ Other concerns? Please list:
☐ Discoloration
☐ Loss of skin tone
☐ Pigmentation
☐ Brown spots
☐ Broken capillaries/veins

_____

Are you wearing contact lenses? ☐ Yes ☐ No
Do you have metal implants? ☐ Yes ☐ No

PREVIOUS PROCEDURES

Which of the following have you had in the past?

☐ Botox / Juvederm/ Radiesse/Restalyne/Collagen (fillers)
☐ Microdermabrasion
☐ Chemical peels
☐ Others-
☐ Waxing
☐ Laser hair removal
☐ Permanent make-up

_____
Client Signature

Reviewed By:

_____ _____
Aesthetician Name Aesthetician Signature

_____ _____
M.D. Name M.D. Signature