



Date: _____

Male Female

SALON & SPA
Believe • Beyond • Be You

CLIENT INTAKE FORM - FACIAL

Name _____ Date of Birth _____

Address _____ City _____

State _____ Zip _____ Email _____

Phone _____ Referral _____

Emergency Contact _____ EC Phone _____

Physician _____ Health Insurance Carrier _____

What are your long-term skin goals? _____

What are your areas of concern? _____

What are your goals for this treatment? _____

Is this your first facial? Yes No If no, when was your last facial? _____

Are you pregnant? Yes No Are you taking birth control pills? Yes No If yes, what type? _____

Are you presently under a physician's care for any current skin condition or other problem? Yes No

Are you presently using (or used in the past) Azlex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alpha Hydroxy Acids? Yes No If yes, when and for how long? _____

Are you now using or have you ever used Accutane? Yes No Do you wear contact lenses? Yes No

Are you presently taking any medications? Yes No If yes, please list _____

Have you had skin cancer? Yes No Do you often experience stress? Yes No

Do you smoke? Yes No Please list any allergies: _____

What skin care products do you use presently? _____

Please check if you are affected by or have any of the following:

- | | | | | |
|---------------------|----------------------------|--------------|------------------|------------|
| Asthma | Fever blisters | Hysterectomy | Sinus Problems | Lupus |
| Cardiac Problems | Headaches-chronic | Skin Disease | Immune Disorders | Depression |
| Anxiety | Hepatitis | Herpes | Epilepsy | Eczema |
| High Blood Pressure | Metal bone, pins or plates | | | |

If affected, please explain or list any other significant issues we should know about: _____

I have read the above information and have given an accurate account of the questions. If I have any concerns, I will address these with my esthetician before the service. I understand that the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature. I give permission to my esthetician to perform the facial service and will not hold the esthetician nor b Salon & Spa accountable for any liability that may result from this treatment. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Client Signature _____ Date _____

Consent to Treatment of Minor: By signature below, I hereby authorize b Salon & Spa to Administer massage, bodywork or facial to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____

