Client Intake Form SPA NAME

**Client Information**

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| --- | --- | --- | --- |
| Name: | [Name] | Date of Birth: | [Date of Birth] |
| Address: | [Address] | Contact: | [Email] |
| Reference: | [Reference] | Emergency? | [Emergency Contact] |
| Physician | [Physician] | Other: | [Other] |

What are your long-term skin goals?

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| What are your areas of concern? | | | | |
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| What are your goals for this treatment? | | | | |
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| Is this your first facial? Yes, No If no, when was your last facial? | | | | |
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| Are you pregnant? Yes, No Are you taking birth control pills? Yes, No If yes, what type? | | | | |
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| Are you presently under a physician’s care for any current skin condition or other problem? Yes No | | | | |
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| 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 | | | | |
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| Are you presently taking any medications? Yes, No If yes, please list | | | | |
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| 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.*

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| --- | --- |
| Date signed: | Date signed |
| Client: | Client Name |
| Client Signature: | Signature: |

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.

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| --- | --- |
| Signature of Parent/Guardian | Signature |
| Date: | [Date] |