Client Intake Form

Facial

Name_____ Phone ( ) _____ Cell ( ) _____

Address _____

City _____ State ___ Zip _____ E-mail: _____

Occupation _____ DOB_____ Male ____Female ____

Referred by: _____

Emergency Contact: _____Relation to you _____ Phone ( ) _____

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1. Is this your first facial? Yes No

2. What is your main concern with your skin? _____
   _____

3. Are you presently under a physician's care for any current skin condition or other problem? Yes No
   If so, please explain_____
   _____

4. Are you pregnant? Yes No

5. Are you taking birth control pills? Yes No
   If so, what type?_____

6. Are you presently using (or used in the past):
   Azelex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alpha Hydroxy Acids?
   If so, when and for how long?_____

7. Are you now using or have you ever used Accutane? Yes No

8. Are you presently taking any medications? Yes No
   If so, please list._____
   _____

9. Do you wear contact lenses? Yes No

10. Do you smoke? Yes No

11. Do you have any allergies to cosmetics, food, or drugs? Yes No
    Please list_____

12. Have you had skin cancer? Yes No
    If so, what?_____

13. Do you often experience stress?
    Yes No

14. What skin care products do you use presently?_____
    _____

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

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

Please explain above problems or list any other significant issues._____

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 understand that the information herein is to aid the therapist in giving better service and is completely confidential.

CANCELLATION POLICY -

- You may cancel your appointment without charge anytime 24 hours before your appointment.
- Same day cancellations will be charged 50% of the scheduled service price.
- If you do not call or show for your scheduled appointment, you will be charged full price for the scheduled service.

Client Signature _____ Date_____

Practitioner Signature _____ Date_____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____Date_____