GENERAL CLIENT INTAKE FORM

CLIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Email: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ ZIP _____

How did you hear about us?

◯ I live/work in area ◯ I was referred by _____

◯ Social media ◯ Other _____

Emergency Contact: _____ Phone: _____

Relationship: _____

GENERAL HEALTH & WELLNESS

Are you currently under the care of a physician? ◯ Yes ◯ No

If yes, please explain: _____

Are you currently under the care of a dermatologist? ◯ Yes ◯ No

If yes, please explain: _____

Do you have any diagnosed medical conditions? _____

Do you have any diagnosed skin conditions? (eczema, psoriasis, rosacea, etc.) _____

Do you believe you have sensitive skin? ◯ Yes ◯ No

If yes, please explain: _____

ALLERGIES & SENSITIVITIES

Do you have allergies to:

Foods: _____

Ingredients / Skincare: _____

Medications: _____

Environmental allergens: _____

Fragrances: _____

Do you have any food aversions or intolerances? _____

Have you ever had an allergic reaction to a skincare product, treatment, or ingredient? ◯ Yes ◯ No

If yes, please explain: _____

Do you have any reactions to sun, heat, or temperature changes? ◯ Yes ◯ No

If yes, please explain: _____

LIFESTYLE & EXPOSURE

What is your current job or vocation? _____

How many hours per day are you outdoors? ◯ <1 ◯ 1-3 ◯ 3-5 ◯ 5+

Do you have pets at home? ◯ Yes ◯ No

If yes, which type(s)? _____

Are you currently pregnant or nursing? ◯ Yes ◯ No

Do you smoke or vape? ◯ Yes ◯ No ◯ Occasionally

Water intake (average): ◯ <2 cups/day ◯ 2-4 cups ◯ 4-8 cups ◯ 8+ cups

MEDICATIONS & SUPPLEMENTS

Are you taking prescription medications? *Include acne medications, hormone therapies, birth control, topical prescriptions, etc.*

_____

Are you taking supplements or herbal products? ◯ Yes ◯ No

If yes, list: _____

Do you currently use Retin-A, retinoids, Accutane, or other topical actives? ◯ Yes ◯ No

Products & last date used: _____

TREATMENT HISTORY

When was your last facial or skincare treatment? _____

Have you ever had:

◯ Microneedling ◯ Chemical peels

◯ Microdermabrasion ◯ Dermaplaning

◯ Laser procedures ◯ Light therapy

◯ Injectables (Botox/filler) Last Treatment: _____

◯ Cosmetic surgery Details: _____

What was your favorite skincare treatment you've ever received? Why? _____

_____

Have you ever had a treatment you did *not* enjoy? What happened? _____

_____

CURRENT SKINCARE ROUTINE

Morning Routine (include brands):

_____

_____

_____

Evening Routine (include brands):

CLIENT SKIN GOALS

What are your top 3 skin concerns?

1. _____
2. _____
3. _____

What results do you hope to achieve from your treatments? _____

ADDITIONAL INFORMATION

Anything else you feel is important for your esthetician to know? _____

CLIENT ACKNOWLEDGMENT

I confirm that all information provided is accurate to the best of my knowledge. I understand that my esthetician does not diagnose medical conditions and that is form is used to ensure safe and appropriate skincare services.

Client Name (Print): _____

Signature: _____ **Date:** _____