Facial Intake Form

(Please print clearly)

Name:

_____

Phone #:

_____

Email:

_____

Date of Birth:

_____

How did you hear about us:

_____

Do you have allergies If yes, which ones?

_____

Yes No Do you ever experience skin breakouts?

Yes No Do you every experience oily shine throughout the day?

Yes No Do you ever experience burning, itching sensation on your skin?

Yes No Do you ever experience flakiness and/or tightness?

Yes No Do you sunbathe or use tanning beds?

Yes No Do you burn easily in moderate sunlight?

Yes No Do you blush easily when nervous?

Yes No Do you have a tendency to redness?

Yes No Do you suffer from sinus problems?

Yes No Do you smoke?

Yes No Do you exercise regularly?

Yes No Do you follow a restricted diet?

Yes No Do you wear contact lenses?

Yes No Are you pregnant or trying to become pregnant?

Yes No Are you taking oral contraceptives?

Yes No Are you lactating?

Yes No Do you experience irritation from shaving?

Yes No Do you experience ingrown hairs?

Yes No Are you currently having or due for your menstrual period?

Have you ever experienced a reaction to any skin care products? If so which ones?

_____

Have you had any health problems past or present? If yes, please specify:

_____

Do you have metal implants, pacemaker or body piercings, if yes which?

_____

Please list any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly:

_____

Rate your level of stress on a scale of 1-10 (1=low, 10 = high)_____

Do you have any special skin problems pertaining to your face or body? If yes, please explain:

_____

What skin type do you feel you have, oily, aging, dry, combination, sensitive, rosacea?

_____

What are your skin care goals?

_____

What skin care products are you currently using?
Soap Cleanser _____ Toner/Moisturizer _____
Masque _____ Exfoliator_____ Eye Products_____
Other _____

Do you currently use Accutane, Retin A, Renova, Adapalene or any other prescription skin care products? **If yes, please list:**

_____

Are you currently using any products that contain the following ingredients (circle all the apply):
Glycolic Acid, Lactic Acid, Exfoliating Scrubs, Hydroxy Acids, Vitamin A Derivatives

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments?
If yes, how long ago, which ones?

_____

How much plain water do you consume daily?

_____

How many alcoholic beverages do you consume weekly?

_____

Do you where SPF on your face? If so what strength? _____Body?_____

If I experience any pain or discomfort during this session, I will immediately inform the esthetician so that the session may be adjusted to my level of comfort. I further understand that esthetics should not be considered as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that licensed estheticians are not qualified to diagnose, prescribe, or treat any physical or mental illness, and nothing that is said in the course of the session given should be construed as such. Because esthetics should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Salon 302 Hair & Spa and the Esthetician updated as to any changes in my medical profile and understand that there shall be no liability on Salon 302 Hair & Spa and the esthetician's part should I fail to do so.

Client Signature/Date:

_____