SPA SERVICES INTAKE FORM:

Client Information:

Client Name: _____ Date of Birth: _____ Male/Female

Emergency Contact: _____ Emergency Phone: _____

Are you taking any medications? If so, please list- including prescription and over-the-counter:

_____

Do you have any of the following health conditions? (Please circle)

AIDS/HIV Cancer Diabetes Hepatitis High/low blood pressure Lupus
Strokes Recent surgeries- if so, please list: _____

Do you have any allergies/sensitivities? (Please circle) Yes / No **If so, please list**: _____

Are you currently pregnant? (Please circle) Yes / No **If so, how far along?** _____

Please describe your current skincare regimen: _____

_____

Are you currently using any of the following? (Please circle)

Retin A/Tretinoin Hydroquinoine Glycolic Acid/Alpha Hydroxy Acid Accutane
Topical Vitman C Birth control pills Hormone Replacement Therapy Sunscreen

In the past 3 months, have you used Retin-A, Renova, AHA's, Retional, or Tretinoin? (Please circle) Yes / No

In the past 6 months, have you received any type of cosmetic injectable? (Please circle) Yes / No

In the past 6 months, have you any type of laser or IPL treatments? (Please circle) Yes / No

Have you ever had a professional skincare service before? (Please circle) Yes / No

Are you currently under the care of a dermatologist? (Please circle) Yes / No

What type of skin do you have? (Please circle) Normal / Oily / Dry / Combination

Please circle any that may apply to your skin: (Please circle)

Breakouts/acne Blackheads/whiteheads Uneven skin tone Rosacea
Excessive oil/shine Wrinkles/fine lines Dull/dry skin Sun damage
Broken capillaries Redness Sun spots/brown spots

What is your biggest skincare concern today? _____

Reviewed by: _____ *(Staff Initials)* Notes: