CLIENT INTAKE FORM

Date:_____ Date of Birth: _____.

First Name:_____ Last Name: _____.

Address: _____ City: _____ State: _____ Zip: _____.

Home Phone: _____ Cell Phone: _____ Email: _____.

Occupation: _____ Hereditary Background: _____.

How did you hear about us?

Have you seen a dermatologist in the past year? YES ☐ NO ☐ If so, list dermatologist's name and reason for the visit.

Have you been under the care of a physician during the last year? YES ☐ NO ☐.
If so, please list the physician's name.

Do you use sunscreen? YES ☐ NO ☐ Sometimes ☐.

Have you ever had any of the following conditions? (circle if applicable)

Acne/HX of scarring	Tumors/growths/cysts	Melasma
Arthritis	Pacemaker/metal implants	History of implants
Diabetes	Hepatitis	Blood clots
Severe headaches/migraines	HIV / Aids	Bleeding disorder
Herpes/Cold sores/Fever blisters	Abnormal wound healing	Autoimmune disease
Seizures/Epilepsy	Keloid Scarring	Vascular Disease
Cancer	Skin Disorders	Bacterial Infection
Chemotherapy/Radiation	Hypopigmentation (lightening)	Fungal Infection
Thyroid Disease	Hyperpigmentation(darkening)	Recurrent Infections
Lupus	Vascular (vein surgery)	Laser treatments
Pregnant/nursing	Edema (swelling)	Cosmetic surgery

List any conditions not mentioned above:

How much water do you consume daily? _____.

How much caffeine do you consume daily? _____.

Do you currently have a sunburn, tan, red face or wind burn? _____.

Are you in the habit of using tanning booths or self tanner? If so, when was the last time?

_____

Do you wear contact lenses or eyeglasses? _____.

Do you have an intolerance to heat or cold? _____.

Have you received any of the following treatments? (circle if applicable)

- Chemical Peel
- Microderm
- Dermaplaning
- Intense Pulsed Light
- Professional Facial
- Facial ultrasound
- Microneedling
- Laser Hair Removal
- Waxing
- Permanent Makeup
- Laser Treatments
- Injectables
- Tattoos

Have you had any other treatments? List here:

_____

Have you ever used any of the following topical / oral medications?

- Accutane
- Renova
- Differin
- Tazorac
- Tretinoin
- Avage
- EpiDuo
- Alpha Hydroxy Acids (i.e. glycolic)
- Beta Hydroxy Acids (i.e. salicylic)
- Retin A (retinol)
- Topical antibiotics
- Hydroquinone

Current medications (including over the counter):

_____

Current dietary supplements including vitamins, herbs, etc.:

Do you smoke? If so, how much?_____.
Do you drink alcohol? If so, how often? _____.

Allergies (food, latex, dairy, seafood, aspirin, medications)? YES☐ NO☐

Explain:_____.
*reaction (shock, hives, rash, swelling)

Please list all products you are currently using on your skin throughout the day including your a.m. and p.m. routine:

Do you have any other concerns that have not been covered on this form?

Please indicate which areas you are interested in improving?

- ☐ Sun spots/brown spots
- ☐ Melasma
- ☐ Preventative Aging
- ☐ Wrinkle/Fine lines reduction
- ☐ Hypopigmentation
- ☐ Sagging skin
- ☐ Crepey skin
- ☐ Large pores
- ☐ Tone/texture
- ☐ Broken capillaries
- ☐ Rosacea
- ☐ Sensitivity
- ☐ Acne
- ☐ Acne Scarring
- ☐ Skin care routine

Additional Comments:

I have freely and truthfully submitted my medical information. I understand it is my responsibility to report any updates or changes of my medical conditions to my provider prior to receiving treatments.

Client Signature: _____.

Print Client Name:_____ Date:_____.