FACELIFT LOUNGE

New client skin intake form

(Circle One) Miss. Ms. Mrs. Mr. Dr. Date:_____

First Name:_____ Last Name:_____

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

Phone Number:_____ Instagram:_____

Email address:_____ Facebook:_____

Date of Birth:_____ Age:_____ Occupation:_____

How would you describe your skin? ____Oily ____Sensitive Dry____ Normal____ Combination____

What is your Ethnicity?_____

How did you hear about this salon?_____

Do you wear contact lenses?_____ Do you have lash extensions?_____

Are you in the habit of using tanning booths? _____Have you had excessive sun exposure in the last few days?:_____

Will you be having excessive sun exposure on a vacation or in the near future?:_____

What are your current top 3 concerns with your skin and what improvements would you like to see?:

1._____

2._____

3._____

Are you currently taking birth control pills or have an IUD?: (Circle one) Yes No

Are you currently pregnant, trying to get pregnant or breastfeeding?: (Circle one): Yes No
If yes, please explain:_____

Are you currently undergoing any hormone therapies or taking any infertility drugs?: (circle one) Yes No
If yes, please explain:_____

Please list Allergies:

FOODS:	MEDICATIONS/LATEX:	PRODUCT INGREDIENTS:	ENVIRONMENTAL:

What Skincare products do you use on a daily basis?:

SKINCARE PRODUCTS:	BRAND: (Only if you know, not necessary)	FREQUENCY:
Cleanser		
Toner		
AM Moisturizer		
PM Moisturizer		
Sunscreen		
Corrective Serum -		
Corrective Serum -		
Facial Scrub		
Mask		
Eye Cream		
Exfoliation -		
Other -		
Other -		

Have you ever received the following procedures or products being used?:

PROCEDURE	HOW OFTEN DO YOU DO THIS?	DATE OF LAST TREATMENT:
Facials		
Chemical peels		
Dermaplaning		
Microdermabrasion		
Laser hair removal		
Esthetic laser treatment (IPL, Fraxel, etc)		
Micro needling		
Radio Frequency (RF) treatment		
PRP		
Facial Ultrasound		
LED treatment		
Facial waxing		
Eyelash/Brow tinting		
Botox		
Injections/filler		
Retinol		
Acne medication		
If yes to injections WHERE on your face were the injections done?		

Medical History/Have you ever had any of the following conditions?:

CONDITION	YES	NO	CURRENTLY:	DATE OF LAST DIAGNOSIS
Acne				
Rosacea				
Cold Sores/fever blisters				
Skin Disorder (i.e. Dermatitis)				
Hypertrophic Scarring (i.e. Keloids)				
Fibroids				
Polysystc overian syndrome (PCOS)				
Diabetes				
Cancer				
Hiv/Aids				
Open Wounds (M)				
Melanoma (M)				
Phlebitis (M)				
Lupus				
Heart Conditons				
Pacemaker/Metal Implants (M)				
Embolism(M)				
Arthritis				
Siezures/Epilepsy (M)				
Severe Headaches/Migraines				
Hepatitis				
Thyroid Disease				
Bleeding disorder (i.e. Anemia)				

Do you have any medical conditions that have not been covered in this form?: (circle one) Yes No

If yes, please explain:_____

May I call you at your home, work or cell phone number to confirm future appointments?: (Circle) Yes No

May I contact you via text/email about future promotions and news?: (Circle) Yes No

May I use your photos on my social media and/or website?: (Circle) yes No

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date:_____

Esthetician Notes/treatments done/Cost of treatment/products recommended/products purchased:

_____

_____

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