New Client Intake Form

Name

First Name | Last Name

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code | Country

E-mail

Phone Number

Area Code | Phone Number

Birthday:

Month | Day | Year

Occupation:

How did you hear about us?

What spa services have you experienced before?

When was your last treatment?

For massage, which level of pressure would you like?

Areas of concern:

Sun damage

Redness/discoloration

Weight/cellulite loss

Pore size/surface condition

Acne/blemishes

____

Would you say your skin is...

Which best describes how the sun affects your skin?

What products are you currently using?

Cleanser

Toner

Exfoliator

AM Moisturizer

PM Moisturizer

SPF

Masque

____

Please read carefully and initial:

	Initial
I am not pregnant*	________
I agree to use recommended post-peel products	________
I am not allergic to aspirin	________
I agree to avoid direct sun exposure for up to 72 hours*	________
I have not used Retin-A for at least 72 hours*	________
I agree to notify esthetician of any concerns	________
I do not have active cold sores	________
I have not taken Accutane for at least 1 year	________
I agree not to wax for 72 hours pre/post skin treatment	________
I agree not to use Retin-A products 5 days pre/post treatment	________
I have no history of or current cancer (including recurring non-malignant skin cancers)	________
No past or present autoimmune illness or disorder	________

*Does not contraindicate certain professional exfoliation methods (ex. Vit C Enzyme, 4 Layer Facial, etc.)

General & Medical Information (all records will remain strictly confidential). Please check all that apply.

Hepatitis	Skin rash	Herpes/cold sore	Acne/blemishes
Active infections	Athletes foot	Cancer	Numbness/tingling
Pinched nerve	Arthritis/tendonitis	TMJ	Migraines/headache
HRT	Chronic pain	Diabetes	Blood pressure issues
Difficulty concentrating	Allergies*	Pregnancy*	Injuries/surgeries last 3 years*
None of the above			

*If yes, please specify below

Allergies: ______________________________

Pregnancy stage: ______________________________

Injuries/surgeries last 3 years: ______________________________

History of trauma (mental, physical, spiritual): ________________

Please take a moment to carefully read the following information and sign where indicated.

If I experience any pain or discomfort during a session I will immediately inform the practitioner so that the technique may be adjusted to my level of comfort. I affirm I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability should I forget to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. **I agree to adhere to the 24-hour weekday/ 48-hour weekend cancellation policy, in order to avoid being charged in part or whole for the service. Clients are expected to pay in full for broken or "no-show" appointments.**

Signature ______________________________