CLIENT INTAKE FORM

Name_____Date_____
Address_____Referred By_____
City/State/Zip_____Birthdate_____
Email_____Phone_____Occupation_____

To confirm future appointments and hear about specials how would you like to be contacted? ❒ *Home* ❒ *Cell* ❒ *Email*

GENERAL HEALTH

Please indicate any Medical conditions that apply.

❒ Blood pressure high / low ❒ Kidney problems ❒ Cold hands & feet ❒ Tuberculosis ❒ Vericose Veins
❒ Anemia ❒ Arthritis, Bursitis ❒ Hepatitis A / B / C ❒ Cancer ❒ Diabetes I / II
❒ Circulatory Problems ❒ Fibromyaligia ❒ Heart Problems ❒ Stroke ❒ Stress Related Illness
❒ Pregnant / Breastfeeding ❒ HIV / AIDS ❒ Sunburn ❒ Skin disease ❒ Eczema
❒ Neck injury Fused Y / N ❒ Herpes Simplex I / II ❒ Psoriasis ❒ Under Doctors Care

Please indicate any items you are using/taking:

❒ Retin A or Similar Medication ❒ Antibiotics ❒ Accutane ❒ Glycolic Products ❒ Tanning Bed
❒ Hormonal Therapy ❒ Chemotherapy ❒ Injectable / Filler

ALLERGIES:

*Please list any known allergies.*_____
Have you had a reaction to a skin care product? ❒ YES ❒ NO If yes, specify_____
Please check if allergic to any of the following:

❒ Aspirin ❒ Glycolic ❒ Pumpkin ❒ Latex ❒ Fragrance ❒ AHA's ❒ Plants / Botanicals ❒ Essential Oils

FACIAL SERVICES:

What type of skin would you say you have? ❒ Normal ❒ Dry ❒ Oily ❒ Combination ❒ Sensitive ❒ Rosacea
Does your skin break out? ❒ Never ❒ Occasionally ❒ Regularly ❒ Stress ❒ Menstrual Cycle
Do you have a skin care regimen? ❒ YES ❒ NO *What Product Line are you using?*_____
Check if included in your regimen: ❒ Cleanser ❒ Exfoliation ❒ Toner ❒ Mask ❒ Serums ❒ Eye cream
❒ Moisturizer ❒ Sunscreen ❒ Retin A ❒ Clarisonic Brush ❒ Clarisonic Opal
Do you use Sunscreen on your face? ❒ None ❒ 15 ❒ 30 ❒ 40 ❒ Higher *How often?* ❒ Daily ❒ Outdoors ❒ Summer only
Check if you've had any of these treatments:

❒ Facial ❒ Waxing ❒ Chemical peel ❒ LED ❒ Laser ❒ Dermafile ❒ Galvanic ❒ Microcurrent ❒ Microdermabrasion ❒ Injectable / Filler

*Have you had any of these treatments in the last month, please specify*_____
*What is your particular concern for your skin today?*_____

PERMISSION TO USE PHOTOGRAPH

I _____ **authorize** *POREFECTION* and its related entities to use my photograph, for educational or promotional purposes, in any type of media, including the Web. I understand that I will not be paid or rewarded for providing this authorization unless agreed prior to the instance of use. ***Signature***_____

- I have read and completed this questionnaire to the best of my knowledge.
- I understand that results are personable, and are not guaranteed.
- 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 are voluntary and I release *POREFECTION* from liability and assume full responsibility thereof.

Client's Signature:_____Date:_____

Rosa Myers, Signature:_____Date:_____