Patient Intake Form

Date:_____

Name: _____ D.O.B.:_____

Address:_____ City:_____ St:_____Zip:_____

Home Phone:_____ Cell Phone:_____

E-mail Address:_____

Emergency Contact:_____ Phone:_____

How did you hear about us (i.e. website, friends name, newspaper, ad, facebook, etc)?

_____

Please list any questions or concerns that you have with your skin/body and/or the reason for your visit:

_____

_____

Which skincare and cosmetic products are you currently using? _____

_____

_____

1) Have you been under the care of a physician, dermatologist, or other medical professional within the past year? ○No ○Yes, explain_____

2) Any recent surgery, including plastic surgery? ○No ○Yes, explain_____

3) Have you had any of the following health conditions in the past or present?

Cancer	□	Headaches	□
Hormone Imbalance	□	Hepatitis	□
High/low blood pressure	□	Fever blisters/cold sores	□
Hysterectomy	□	Immune disorders	□
Spinal injury	□	HIV/AIDS	□
Diabetes	□	Poor circulation	□
Heart problem	□	Insomnia	□
Varicose veins	□	Skin diseases/skin lesions	□
Arthritis	□	Any active infections	□
Asthma	□	Eczema	□
Epilepsy	□	Scar easily	□

4) Do you smoke? ○No ○Yes

5) Do you follow a restricted diet? ○No ○Yes

6) What is your stress level? ○High ○Medium ○Low

7) List any medications or vitamins you are taking regularly:_____

8) Do you wear contact lenses? ○No ○Yes

9) Have you been exposed to the sun or a tanning bed within the last 48 hours? ○No ○Yes

10) Do you use or have you ever used Adapalene Hydroxl Acid, Glycolic Acid, AHA, Accutane, Retin-A, Renova, Deferin, Salicylic Acid or any vitamin A derivative product (**Accutane**)? ○No ○Yes

If yes, please explain:_____

11) Have you ever experienced an allergic reaction to any of the following? (please circle any that apply)

Cosmetics	Medicine	Food	Sunscreens	Iodine	AHAs
Fragrance	Shellfish	Latex	Other:_____		

If yes, please explain:_____

12) Have you ever experienced claustrophobia? ○No ○Yes

Female Clients Only

13) Are you taking any oral contraceptives? ○No ○Yes

14) Are you pregnant or trying to become pregnant? ○No ○Yes

15) What is the date of your last menstrual cycle?_____

16) Are you experiencing any menopause problems? ○No ○Yes

I consent to photos being used for office use. ○No ○Yes

I consent to photos being used for advertising. ○No ○Yes

I would like to receive promotions and communications via email. ○No ○Yes

I understand, have read and fully completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. While all treatments are recommended to achieve the best possible results, I do understand that not all treatments will have the same results on every client, therefore no guarantee can be given. I also understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the technician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release Epic MedSpa, LLC and my esthetician from liability and assume full responsibility thereof.

Client signature:_____ Date:_____

Update:
I have reviewed my confidential history form and have no changes to my health history and haven't started any new medications.

Client signature:_____ Date:_____

Client signature:_____ Date:_____