Client Intake Form

Name _____

Address _____**Apt**____**City/St**_____**Zip**_____

Phone Primary_____ **Alternate**_____

Email _____

Birthday month+day_____□under 21 □21-30 □31-40 □41-50 □51-60 □61-70 □71-80 □81+

How did you hear about us?_____

1. **Have you had any of these health problems in the past or present?**
   □ Cancer □ Diabetes □ Epilepsy □ Heart problem □ Hysterectomy □ Systemic disease
   □ Hormone imbalance □ Spinal injury □ Thyroid condition □ Varicose veins □ HIV/AIDS
   □ Hepatitis □ Please indicate other _____

2. **Are you on any prescription medication or prescription skin care?** □ Yes □ No
   If yes, please list them:
   _____

3. **What skin care products are you currently using?**
   □ Cleanser □ Toner □ Exfoliation □ Serum □ Eye Cream □ Moisturizer □ Sunscreen □ Mask

   If you'd like to include Brands: _____

4. **Have you ever had peels, laser, microdermabrasion or any resurfacing treatment?** □ Yes □ No

   If yes, which one & when was the last date of treatment: _____

5. **Are you currently using any products that contain the following ingredients?** □ hydroquinone
   □ glycolic acid □ salicylic acid □ lactic acid □ AHA product or vitamin A derivatives (i.e. retinol)

6. **What type of massage pressure do you prefer?** □ Soft □ Medium □ Firm

7. **What are your skin care goals?** □ Reduce Acne □ Deep Cleansing □ Reduce Pigmentation
   □ Anti-Aging □ Alleviate Skin Redness/Rosacea □ Alleviate Eczema, Dermatitis, Psoriasis
   Additional notes or instructions:

8. **If extractions are needed, do you prefer** □ Light □ Medium □ Leave to discretion of Therapist

9. **Do you have any allergies or have you ever had any reaction to the following list?**
   □ Cosmetics □ Medicine □ Essential Oils □ Pollen □ Food □ AHA acids □ Sulphur □ Fragrance
   Any additional info:

10. **Are you taking any oral contraception?** □ Yes □ No
    Are you pregnant or trying to become pregnant? □ Yes □ No

Please read the following information:

I understand that the therapeutic session I receive is provided for the basic purpose of skin care and relaxation. I understand that some redness/irritation is possible and to ask my therapist about follow-up care. If I experience any pain or discomfort during this session I will immediately inform the therapist. I affirm that the above information is accurate and true to the best of my knowledge and to keep the practitioner updated as to any changes in my medical profile. I understand that there shall be no liability on the practitioner's part should I fail to do so. I do hereby waive, release and forever discharge Karen Wood from any and all responsibility or liability related to my service.

Signature_____**Date**_____