NEW CLIENT INTAKE FORM

CLIENT'S INFORMATION

FULL NAME:	PREFERED PRONOUNS:
DATE OF BIRTH:	AGE:
ADDRESS:	
CITY:	ZIP CODE:
E-MAIL:	PHONE:

EMERGENCY CONTACT

NAME:	
RELATIONSHIP:	PHONE:

SKIN CONCERNS & GOALS

If there was something you could change or improve about your skin, what would it be?

SKIN CARE ROUTINE

MORNING	EVENING

MEDICAL HISTORY

( ) ENDOCRINE DISORDERS	( )COLD SORES	( ) HORMONAL CONDITIONS
( ) DIABETES	( ) HIGH BLOOD PRESSURE	( ) HEART DISEASE
( ) AUTOIMMUNE DISEASES	( ) EPILEPSY OR SEIZURES	( ) IMMUNOSUPRESSION
( ) Other Medical Concerns:		

List all prescription medications, over-the-counter medications, topical medications, vitamins, herbs, and supplements currently used._____._____._____

Check all that apply:
□ Isotretinoin / Accutane □ Topical antibiotics □ Corticosteroids / immunosuppressants
□ Hormonal medications □ Acne medications □ Tretinoin
□ Oral antibiotics □ Anticoagulants / blood thinners □ Photosensitizing medications
□ None
Accutane history / last dose: _____
Any medication-related photosensitivity or abnormal skin reaction? □ No □ Yes___

Currently under the care of a physician, dermatologist, or other healthcare provider?
□ No □ Yes If yes, please describe: _____

LIFESTYLE

Sleep quality: □ Good □ Fair □ Poor
Stress level: □ Low □ Moderate □ High
Pregnant, trying to conceive, or breastfeeding? □ No □ Yes
Are you peri-post or mid menopause□ No □ Yes
Do you shave your face?□ No □ Yes
Do you have botox, fillers or other injections in the face?□ No □ Yes
Exercise frequency per week _____
Frequent sweating, swimming, sauna, steam room, or hot yoga? □ No □ Yes
Tobacco / nicotine use: □ No □ Yes Alcohol: □ None □ Occasional □ Regular
Sun exposure / tanning bed use: □ No □ Yes
Occupation _____
Occupational or environmental exposures that may affect skin: _____

ALLERGIES + SENSITIVITIES

□ Medication □ Latex □ Adhesives □ Fragrance
□ Skincare ingredients □ Foods □ Other: _____ □ None

Previous reactions to skincare treatments or products?
□ No □ Yes If yes, please describe: _____

History of contact dermatitis or significant skin sensitivity? □ No □ Yes

RECENT TREATMENTS + PROCEDURES

Within the last 2-4 weeks, have you received any of the following in the treatment area?

□ Facial / professional exfoliation □ Chemical peel □ Microneedling / microchanneling
□ Nano infusion □ Laser / IPL □ Waxing / threading
□ Injectable treatment □ Dermaplaning □ Other resurfacing treatment □ None

Treatment / date: _____

MODALITY-SPECIFIC CONTRAINDICATION SCREENING

Chemical Peel / Chemical Exfoliation
□ Active infection □ Active herpes simplex lesion □ Significant barrier impairment
□ Active dermatitis / eczema flare □ Recent sunburn / excessive UV exposure
□ Recent waxing / threading / depilatory treatment □ Recent laser / resurfacing procedure
□ Current or recent isotretinoin use
□ Pregnancy/nursing □ Abnormal wound healing / scarring history □ None

High Frequency
□ Pacemaker / implanted electronic medical device □ Significant cardiac condition
□ Significant metal or electronic implant in treatment area
□ Active infection / compromised skin □ Seizure disorder / epilepsy
□ Pregnancy/nursing □ Known sensitivity to electrical modalities
□ Other medical concern requiring provider clearance □ None

LED Phototherapy – Celluma
□ Photosensitive disorder □ Photosensitizing medication □ Photosensitizing supplement
□ History of light-triggered seizures □ Seizure disorder / epilepsy
□ Significant photosensitivity □ Known reaction to LED / phototherapy
□ Active eye condition / light sensitivity □ Pregnant/nursing
□ Recent photosensitizing treatment □ None