

Date: _____

Medical Intake Form

Name: _____ Birth Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Emergency Contact: (Name & Phone) _____

Primary Physician: _____

Do we have permission to contact you by phone or leave messages? Yes No

Preferred method of contact: Phone Text E-Mail

Do we have permission to show your photos for educational purposes? Yes No

Concerns

What concerns you most about the overall appearance of your skin? (check all that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Acne Scarring | <input type="checkbox"/> Age Spots |
| <input type="checkbox"/> Blackheads | <input type="checkbox"/> Body Acne | <input type="checkbox"/> Broken Blood Vessels |
| <input type="checkbox"/> Bumps on back of arms | <input type="checkbox"/> Cellulite | <input type="checkbox"/> Cysts/Nodules |
| <input type="checkbox"/> Dehydrated Skin | <input type="checkbox"/> Dull Complexion | <input type="checkbox"/> Excessive Facial Hair |
| <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Fine Lines/Wrinkles | <input type="checkbox"/> Frequent Breakouts |
| <input type="checkbox"/> Large Pores | <input type="checkbox"/> Loss of Lashes/Brows | <input type="checkbox"/> Melasma/Brown Spots/Patches |
| <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Redness | <input type="checkbox"/> Rough/Uneven Skin Texture |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Sagging Skin | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Under Eye Puffiness/Dark Circles | <input type="checkbox"/> Other: _____ | |

How would you describe your skin? Oily Dry Combination Sensitive

How would you describe your stress level? Little Moderate High Severe

Do you feel your stress level may be affecting the health of your skin? Yes No

Are you in good health overall? Yes No Concerns: _____

History

Are you currently under the care of a physician? ___Yes ___No Explain:_____

Do you have any allergies to foods or medications? ___Yes ___No Explain:_____

Are you currently on any medications either topical or oral? ___Yes ___No If yes, please list:

Ethnic Background (Parents, Grandparents and Great Grandparents): _____

How do you heal after an acne breakout, cut or scratch? ___ No scar ___ Red ___ Brown (PIH)

Do you smoke? ___Yes ___No

Are you prone to cold sores? ___Yes ___No If yes, date of last cold sore? _____

Do you have an allergy to Latex? ___Yes ___No

Do you tan in the sun or in tanning beds/booths? ___Yes ___No

Please check the skincare products you are currently using:

___Cleanser ___Toner ___Serum ___Scrub ___Mask ___Eye Cream ___Moisturizer

___Sunscreen ___Self Tanner ___Concealer ___Makeup ___Other_____

Anything else we should know:_____

The answers I have provided are true and correct to the best of my knowledge.

Client Signature

Date

Provider Signature

Date

Informed Consent

Make sure your client signs the consent form prior to receiving treatment.

A sample consent form follows that you may customize with your company header and contact information. You may want to have your attorney review the form prior to use.

Informed Consent

I, _____ give my consent for the following procedure:
dermaplaning to be performed by _____.

Dermaplaning is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built up dead skin cells and vellous hair. Following treatment skin will be smoother, softer and better able to absorb the active ingredients in treatment and home care products.

I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellous hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts.

I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

While every precaution will be taken to avoid nicks, cuts and scratches, I understand the risks and consent to treatment today.

Name

Signature

Date

Witness

Client Name: _____ **Date:** _____

Treatment Record

Concerns: _____

Desired Outcome of Treatment: _____

Medical History Reviewed? Yes No Informed Consent Signed? Yes No Photos? Yes No

Skin Analysis: _____

Service(s) Provided: _____

Areas Treated: Face Neck Décolleté Body: _____

Cleanser: _____ Skin Prep/Toner: _____

Exfoliation: Scrub Dermaplaning Microdermabrasion Enzyme Peel Other: _____

Details: _____

Peel: _____ # of Layers: _____ Time: _____ Heat Level (1-10): _____

Extractions: Yes No Details: _____

Mask: Yes No Details: _____

Other Modalities: Steam Clarisonic SkinScrubber MicroCurrent LED MicroNeedling

HighFrequency Galvanic UltraSound UltraSonic Oxygen Other: _____

Settings/Details: _____

Serum(s): _____ EyeCream: _____

Moisturizer: _____ SPF: _____

Notes: _____

Products Recommended: _____

Products Purchased: _____

Next Treatment: _____ Date: _____

Follow Up Date: _____ Result: _____

Provider: _____