Facial Intake Form

Name: _____ Date: _____
Phone: _____ Email: _____

Skincare / Health History:

Is this your first facial? YES NO
If NO, how long ago was your last one? _____

Within the last year, have you been under the care of a dermatologist? YES NO
If YES, please specify: _____

Are you currently using or have ever used any prescription medications for acne or other skin conditions including but not limited to Retin A or Accutane? YES NO
If YES, please specify: _____
If YES, how long has it been since your last use? _____

Within the last year, have you undergone any facial surgeries, procedures, or tattoos? YES NO
If YES, please specify: _____

Do you currently have any injuries? YES NO
If YES, please specify: _____

Have you had any health conditions in the recent past or present? YES NO
If yes, please specify: _____

Do you smoke? YES NO

Do you go tanning? YES NO

Do you wear sunscreen / sunblock? YES NO

Please list any medications, supplements, vitamins, diuretics, etc. that you take regularly:
_____
_____

Are you pregnant or breastfeeding? YES NO

Please list any known reactions, allergies or sensitivities (ingredients, etc.):
_____
_____

Please rate your level of stress: Low 1 2 3 4 5 6 7 8 9 10 High

Please list any skincare concerns you currently have:

_____

_____

_____

Please list the skincare products you regularly use:

_____

_____

Please list any other information you would like your esthetician to know regarding your session today:

_____

_____

_____

Your signature below indicates that you have provided accurate information. Your esthetician cannot be held responsible for any information not disclosed on this form prior to treatment.

_____ _____

Client Signature *Date*

_____

Client Printed Name