Client Intake Form for Chemical Peels & Microdermabrasion

General Information

Name _____ Birthday _____
Address _____
City _____ State/Province _____ Zip/Postal Code _____
Phone # _____ Email_____
Occupation _____
Emergency Contact Name _____ Phone # _____
Would you like to be added to our email list for specials and discounts? ☐Yes ☐No
How did you hear about us? _____

Medical History

Do you currently or have you had any of the following? Please check all that apply:

☐ Active Infection	☐ Arthritis	☐ Asthma
☐ Autoimmune Disorder	☐ Aids/HIV	☐ Bleeding Disorder
☐ Blistering Sunburns	☐ Cancer	☐ Cardiac Valve Disease
☐ Circulation Problems	☐ Cold Sores	☐ Collagen Disorder
☐ Diabetes	☐ Easy Bruising	☐ Eczema
☐ Endocrine/Hormonal Issues	☐ Eye Problems	☐ Fatigue
☐ Fibromyalgia	☐ Headaches/Migraines	☐ Heart Condition
☐ Hepatitis	☐ High/Low Blood Pressure	☐ Hormonal Imbalance
☐ Insomnia	☐ Joint Injury	☐ Multiple Sclerosis
☐ Muscle Pain/Spasms	☐ Permanent Makeup	☐ Psoriasis
☐ Pigmentation Disorder	☐ Melanoma	☐ Recent Surgery
☐ Scleroderma	☐ Sensitive Teeth	☐ Shingles
☐ Skin Cancer	☐ Skin Injury	☐ Stroke
☐ Unusual Moles	☐ Varicose Veins	☐ Vision Problems
☐ Other: _____		

Are you or could you be pregnant? ☐Yes ☐No
Are you breastfeeding? ☐Yes ☐No
Do you suffer from photosensitivity? ☐Yes ☐No
Do you have a history of easy/excessive Hyperpigmentation? ☐Yes ☐No
Have you ever had an adverse reaction to cosmetic treatments? ☐Yes ☐No
Do you form keloid scars? ☐Yes ☐No
Have you had unprotected sun exposure in the last 2 weeks? ☐Yes ☐No
Are you planning a vacation in the sun in the next 3-6 months? ☐Yes ☐No
Do you wear contact lenses? ☐Yes ☐No
Do you use tanning beds? ☐Yes ☐No

Do you have any other allergies? ☐Yes ☐No
If yes, please list: _____

Are you currently on any blood-thinning prescription or non-prescription drugs? ☐Yes ☐No
If yes, what kind? _____

Are you currently taking any medications? ☐Yes ☐No
If yes, what kind? _____

Have you had any facial or dermatology services in the past 30 days? ☐Yes ☐No
If yes, please explain: _____

Have you had any permanent or semi-permanent makeup services completed previously?
☐Yes ☐No
If yes, please explain: _____

Have you used Accutane, Retin-A, Renova, AHAs or Retinal products in the last twelve months?
☐Yes ☐No
If yes, please explain: _____

Have you received Botox, Lip Fillers, Restylane, Juvéderm or Collagen injections in the last 6 months? ☐Yes ☐No
If yes, when: _____

Have you used any of the following hair removal methods in the past 6 weeks?

Shaving	☐Yes ☐No
Waxing	☐Yes ☐No
Electrolysis	☐Yes ☐No
Plucking/Tweezing	☐Yes ☐No
Stringing	☐Yes ☐No
Depilatories	☐Yes ☐No

Please describe your current skin care regimen: _____
_____
_____

What concerns do you have regarding your skin? Please check all that apply.

☐Acne	☐Ageing Hands	☐Brown Spots
☐Deep Wrinkles	☐Dry/Oily Skin	☐Excessive Sweating
☐Facial/Body Hair	☐Facial Veins	☐Fine Wrinkles
☐Leg Veins	☐Lip Lines	☐Loose Skin
☐Marionette Line	☐Nasolabial Creases	☐Scars
☐Skin Discoloration	☐Rosacea	☐Thin Lips
☐Toenail Fungus	☐Other: _____	

Skin Typing

Please check the statements that most apply to you.

Score	0	1	2	3	4
What color are your eyes?	Light Blue, Gray Green ☐	Blue, Gray ☐	Green ☐	Brown ☐	Brown Black ☐
What is the natural color of your hair?	Sandy Red ☐	Blond ☐	Chestnut Dark Blond ☐	Dark Brown ☐	Black ☐
What is the color of your skin that is not exposed to the sun?	Reddish ☐	Very Pale ☐	Pale with Beige Tint ☐	Light Brown ☐	Dark Brown ☐
How many freckles do you have on unexposed areas of your skin?	Many ☐	Several ☐	Few ☐	Incidental ☐	None ☐

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling ☐	Blistering followed by peeling ☐	Burn sometimes followed by peeling ☐	Rare burns ☐	Never burn ☐
To what degree do you turn brown?	Hardly or not at all ☐	Light color ran ☐	Reasonable tan ☐	Tan very easy ☐	Turn dark brown quickly ☐
Do you turn brown within several hours after sun exposure?	Never ☐	Seldom ☐	Sometimes ☐	Often ☐	Always ☐
How does your face react to the sun?	Very sensitive ☐	Sensitive ☐	Normal ☐	Very resistant ☐	Never had a problem ☐

Tanning Habits

Score	0	1	2	3	4
How often are you exposed to sun (or artificial sunlamp/tanning cream)?	Never ☐	Hardly ever ☐	Sometimes ☐	Often ☐	Always ☐
How long ago was the area to be treated exposed to the sun or artificial sunlamp/tanning cream)?	3+ months ago ☐	2-3 months ago ☐	1-2 months ago ☐	Less than a month ago ☐	Less than 2 weeks ago ☐

Total Score: _____

Skin Type Score	Fitzpatrick Skin Type
0-7	1
8-16	2
17-25	3
25-30	4
30-35	5
Over 35	6

Fitzpatrick Skin Type: _____

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed _____ Signature _____ Date _____

Technician Name _____ Signature _____ Date _____