Confidential Client Intake Form for Dermaplaning

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:

Abrasions	Acne	Autoimmune Disorder
Bleeding Disorder	Broken Capillaries	Cuts
Dermatitis	Eczema	Fever
Hematoma	Hemophilia	Hepatitis
Herpes	Hypersensitive Skin	Inflammation
Pregnant/Breastfeeding	Rosacea	Skin Cancer
Skin disease	Sunburn	Warts
Other: _____________		

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? ____

Skin Care History

Check the products that you currently use (please select all that apply):

Body Lotion	Body Soap	Body Scrub
Cleansing Cream	Day Cream	Eye Makeup Remover
Eye Cream	Exfoliants	Facial Soap
Facial Scrub	Hand Cream	Neck Cream
Night Cream	Skin Toner/Astringent	Other: _____________

What type of skin do you have?
Normal Oily Dry Combination Unsure

Have you had any facial or dermatology services in the past 30 days? Yes No

If yes, please explain: ____

Have you used Retin-A, Renova, AHAs or Retinal products in the last three 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

Important Information

What are your main concerns? Please select all that apply:

Acne/Breakouts	Age spots	Aging
Blackheads/Whiteheads	Broken Capillaries	Clogged Pores
Dark Eye Circles	Dark Spots	Dull/Dry Skin
Enlarged Pores	Excessive Oil/Shine	Hyperpigmentation
Redness	Rosacea	Scarring
Sun Damage	Uneven Skin Tone	Wrinkles/Fine Lines
Other: ____________		

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**
________________________________	____________________________	____________