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)

___Acne ___Acne Scarring ___Age Spots

___Blackheads ___ Body Acne ___Broken Blood Vessels

___Bumps on back of arms ___Cellulite ___Cysts/Nodules

___Dehydrated Skin ___Dull Complexion ___Excessive Facial Hair

___Facial Veins ___Fine Lines/Wrinkles ___Frequent Breakouts

___Large Pores ___Loss of Lashes/Brows ___Melasma/Brown Spots/Patches

___Oily Skin ___Redness ___Rough/Uneven Skin Texture

___Rosacea ___Sagging Skin ___Sun Damage

___Under Eye Puffiness/Dark Circles ___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:________________________________________________________________________