Client Information

Facial Treatment Intake Form

Date: _____

Name: _____Date of Birth: _____Age: _____

Phone: _____ Email: _____

Emergency Contact (Name & Phone):

_____

General Information

How did you hear about us? _____

Is this your first professional facial? ☐ Yes ☐ No

If no, how often do you receive facials? _____

Medical History

(Please check all that apply)

☐ Diabetes ☐ Epilepsy ☐ Heart Conditions

☐ High/Low Blood Pressure ☐ Skin Cancer (current or past)

☐ Allergies (list below) ☐ Claustrophobia

☐ Pregnant/Breastfeeding

☐ Other conditions: _____

List any allergies (including to skincare ingredients, nuts, latex, etc.):

Current Medications (including Accutane, Retin-A, blood thinners, antibiotics):

Recent medical procedures (chemical peel, laser, injections, surgery, etc.):

Skin History

Primary skin concerns:

☐ Acne ☐ Blackheads/Whiteheads ☐ Sensitivity/Redness

☐ Dryness/Dehydration ☐ Oily/Shine ☐ Hyperpigmentation/Dark Spots

☐ Fine Lines/Wrinkles ☐ Uneven Texture

Other: _____

Current skincare routine (products used):

Cleanser: _____ Toner: _____

Moisturizer: _____ SPF: _____

Treatments/Serums: _____

Do you use:

☐ Retinoids/Retin-A ☐ AHA/BHA acids ☐ Benzoyl Peroxide

☐ Accutane (if yes, stop date: _____)

Have you had any of the following in the past 2 weeks?

☐ Waxing ☐ Chemical Peel ☐ Microdermabrasion

☐ Botox/Fillers ☐ Laser Treatments

(If yes, specify date: _____)

Lifestyle

Average daily water intake: _____ cups

Average hours of sleep: _____

Sun exposure/tanning habits: ☐ Rare ☐ Occasional ☐ Frequent

Smoke or vape? ☐ Yes ☐ No

Treatment Goals & Preferences

What are your top goals for today's facial?

Preferred pressure during massage: ☐ Light ☐ Medium ☐ Firm

Areas of sensitivity or to avoid: _____

Consent & Policies

I understand that facial treatments are not a substitute for medical care. I have disclosed all known medical conditions and agree to inform the esthetician of any changes.

Signature: _____ Date:_____