Tree of Life Massage & Wellness - Skin Care Intake Form

Name:_____ Phone:_____ DOB:_____

Address:_____ City: _____ State:_____ Zip:_____

Email:_____ Male:_____ Female:_____

Occupation:_____ Referred by:_____

Emergency Contact:_____ Phone:_____

1. Is this your first facial? Yes No -If no, give approximate date of last facial:_____

2. What are your primary skin care concerns? _____

_____

3. Are you currently under a doctor's care for any skin conditions? Yes No If yes, list:_____

4. Do you smoke? Yes No If yes, how many cigarettes per day?_____ 5. Do you wear contacts? Yes No

6. Have you ever had an allergic reaction to cosmetics, AHA's, iodine, shellfish, sulfur, sunscreen, latex, pollen, food or drugs? Yes No -- If yes, please list and explain:_____

7. Have you had skin cancer? Yes No --If yes, please give dates, areas affected, and explanation of treatment or resolution: _____

8. Do you use sunscreen regularly? Yes No --If no, what prevents regular use? _____

9. What skin care products, if any, do you currently use?_____

_____

10. What results would you like to see TODAY?_____

11. What LONG TERM results would you like to achieve with advanced skin treatments?_____

_____

12. Please circle if you are affected by any of the following conditions: Asthma Sinus Problems Hysterectomy Fever Blisters Cardiac Problems High Blood Pressure Chronic Headaches Pace Maker Metal Implants Herpes/Shingles Lupus Immune Disorder Epilepsy Hepatitis Eczema Psoriasis Diabetes Depression Anxiety Chronic Skin Condition/Disease Keloids HIV Thyroid Problems Cancer

Please explain any conditions circled above or any significant issue not listed:_____

_____

13. Are you currently taking any products that contain: Glycolic Acid____ Lactic Acid____ Hydroxy Acid____ Retinol/Vitamin A____ -If so, please list and explain:_____

14. Have you recently had any of the following: Chemotherapy____ Skin Sensitivity____ Microdermabrasion____ Laser____ Peels____ Other Exfoliation____ Facial Hair Removal____ Other_____

15. Please list all medications you have taken within the last 30 days (Include all hormones, birth control pills, prescriptions, vitamins/supplements and herbs):_____

_____

16. How much is your daily water intake? _____ cups, or _____ ounces.

17. How much caffeine consumption daily?_____ Alcohol consumption?_____

18. How many hours of sleep do you average per night? _____ Explanation:_____

19. Are you claustrophobic? Yes No -If so, please explain:_____

20. What are the services that best interest you? Assessment/Education Microdermabrasion Acne Treatments Chemical Peels Dermaplaning Light Therapy Body Wraps Detoxification Services Body Scrubs Paraffin Treatments

(Questions 21 & 22 - Females only)

21. Are you pregnant or breastfeeding? Yes No

22. Date of last period:_____ - Do you experience monthly hormonal break outs? Yes No

INFORMED CONSENT: You acknowledge that any services we offer are not intended to diagnose or cure any condition. Any information exchanged with you is educational in nature and is not a substitute for medical care. Any personal or health information you share with us will be used to provide the best care and recommendations for your specific needs. Your information is confidential and will be safeguarded. You understand that although the esthetician/skin care professional will take precautions to minimize adverse reactions, any skin treatment is highly individual and adverse reactions could occur. You consent to receive skin care services and release the esthetician and Tree of Life Massage & Wellness, LLC from liability resulting from any of these services.

I have read the policies of Tree of Life Massage & Wellness and understand that a fee will be charged for services that are cancelled with less than 24 hours notice.

Client Signature: _____ Date:_____

Consent To Treat Minor: My signature below confirms my consent for my minor child or dependant to receive skin care services performed by any licensed practitioner at Tree of Life Massage & Wellness, LLC.

Parent/Guardian Signature:_____

Printed Name:_____ Date:_____

(For Future Repeat Appointments ONLY) Please initial and date in a box below to reconfirm agreement to policies, consent for treatment, and that you have updated your service provider of any changes that may affect your care, i.e. medication changes, recent procedures, allergies, pregnancy, etc.		
1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.