SKIN VITALITY

Experts in Aesthetics

CONFIDENTIAL INTAKE FORM

Date:_____ Full Name: _____ Date of Birth _____

Address:_____City_____State:_____Zip:_____

Home Phone:_____ Mobile Phone: _____Email:_____

Preferred Method of Contact (Circle One) Email Home Phone Mobile Phone

Occupation: _____

How did you hear about our office? (Check all that apply)

- Referral (Name)_____
- Internet Search
- Article
- Facebook
- Walk-In
- Other _____

What are your main areas of concern?

What have you done about this so far?

Medical History:

Please list all known allergies and/or reactions, including but not limited to interactions to cosmetics, fragrance, metals, latex, aspirin, lidocaine, iodine, other medications and foods.

How would you describe your overall health? (Circle One) Excellent Good Fair Moderate Poor

Are you currently taking: (Circle all that apply)

Hormones HRT (Hormone Replacement Therapy) Mood Altering/Anti-Depressant

If you circled any of the above, please use this space to explain (ie: type and duration):

Do you take vitamins, minerals or protein supplements? (If yes, please list which one(s) and the daily dosage taken)

- No
- Yes_____

Do you smoke? (If yes, please indicate the number of years and how much per day)

- No
- Yes_____

Is your stress level: (Circle One) High Medium Low

Do you normally sleep well? (Circle One) Yes No

Do you take oral contraceptives? (Circle One) Yes No

Are you pregnant, or trying to get pregnant? (Circle One) Yes No

Do you experience hormone imbalances? (Circle One) Yes No

Do you wear contact lenses? (Circle One) Yes No

Lifestyle

Please Circle the answer that best applies:

Do you exercise regularly?	Yes	No
Do you follow a fat free diet?	Yes	No
Do you follow a low carb diet with normal/high fat?	Yes	No
Do you restrict sugar in your diet?	Yes	No
Do you have a high protein diet?	Yes	No
How any glasses of water do you consume daily?	1 or less	2+ cups
How many glasses of caffeinated TEA do you consume daily?	1-3 cups	4+ cups
How many glasses of caffeinated COFFEE do you consume daily?	1-3 cups	4+ cups

How often do you consume alcoholic beverages?

Are you a Vegetarian or Vegan? (If yes, please indicate which)

- No
- Yes _____

Have you ever had any of the following: (Check all that apply.)

○ Fever Blister/Cold Sore Herpes	○ Heart disease or conditions	○ Arthritis
○ Cancer	○ Pacemaker or Valve Replacement	○ Keloid Scarring
○ Diabetes	○ Metal implants	○ Thyroid imbalance
○ Epilepsy	○ Any active infections	○ Blood clotting abnormalities
○ High Blood Pressure	○ Hepatitis	○ Other _____
○ Joint Replacement	○ HIV/AIDS	

If you checked any of the boxes above, please use this space to elaborate (ie: when, how often, etc)

Skin Type and Condition

How would you describe your skin? (Circle One) Normal Combination Oily Dry Red/Sensitive Not Sure

Do you experience (Check all that apply)

○ Flakiness or scaly skin	○ Redness
○ Tightness	○ Excessive oily shine during the day

Do you blush easily?

- ○ No.
- ○ Yes, due to emotions.
- ○ Yes, due to foods.
- ○ Yes, due to temperature change

What are your skin challenges? (Check all that apply)

○ Aging	○ Hyper/Hypo-pigmentation	○ Keloids
○ Acne	○ Rashes/Allergies	○ Eczema
○ Laxity or Sagging Skin	○ Dryness	○ Sun Spots/Sun Damage
○ Fine lines and wrinkles	○ Scars	○ Other _____

Have you ever had (check all that apply an indicate how recently you have had the service)

○ Peels	○ Microdermabrasion or Dermablading	○ Injectables
○ Botulinum Toxin	○ Cosmetic Surgery	○ Laser/ablative resurfacing/ partially ablative
○ Microneedling	○ Laser Hair Removal	○ IPL/BBL/VPL

What is your present skin regimen? (Check all that apply and indicate brand used)

○ Soap and water only	○ Cleanser
○ Toner	○ Moisturizer
○ Mask	○ Exfoliation
○ Sunblock daily	○ Other

Have you ever used or are you currently using: (Check all that apply and indicate start and end date of usage.)

○ Accutane	○ Topical cortisone
○ Differin Gel/Adapalene	○ Hydroquinone
○ Topical Antibiotics	○ Retin-A/Retinoic Acid or Tretinoin
○ Anti-fungal nail treatments	○ Alpha hydroxy acids

Does your skin (CIrcle all that apply) Heal quickly Scar Pigment Easily

Have you had any recent sun or tanning bed exposure? (Circle one) Yes No

What best describes your skin in the sun? (Circle One) Sun sensitive Sun tolerant Sun resistant Not sure

Are you under treatment for current skin conditions? If yes, please list in the space provided.

- ○ No
- ○ Yes _____

<u>Special Cautions</u>

Describe any relevant hereditary history you may have:

Do you have any phobias? If so, please detail below. (ie: claustrophobia)

Is there any other information you would like for us to know?

-Continue to signature page on back-

I certify that the information provided is accurate. I am aware that it is my responsibility to inform the providers at Skin Vitality of my current health conditions in addition to updating this document. I understand that a current medical history is essential for the caregiver to execute appropriate treatments and procedures in order to achieve my skin improvement goals.

Signature_____ Date_____

Cancellation Policy

We are honored to be a part of your beautiful journey and appreciate the trust you put in us. To ensure we mutually achieve our goals and enjoy a respectful, fulfilling professional relationship, we ask that you respect the time we have reserved for your upcoming services by adhering to our rescheduling and cancelation policy. Any appointments that are cancelled less than 48 business hours prior to the appointment time are subject to a cancellation fee. This fee will amount up to half the cost of the scheduled service. Clients who miss their appointments without giving any prior notification will be charged in full for the scheduled service. Any packages or gift cards purchased will have the amount of the service be deducted from the balance.

I certify that I have read and understand the above cancellation policy.

Signature_____ Date_____