

CLIENT INTAKE FORM **ac** MEDSPA

NICE TO MEET YOU

FULL NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOBILE PHONE OK TO LEAVE MESSAGE HOME PHONE OK TO LEAVE MESSAGE WORK PHONE OK TO LEAVE MESSAGE

EMAIL ADDRESS _____

HOW WOULD YOU LIKE TO BE NOTIFIED?
CIRCLE ALL THAT APPLY telephone email text message (list carrier _____)

EMERGENCY CONTACT NAME AND PHONE NUMBER _____

OCCUPATION _____

HOW DID YOU HEAR ABOUT US? IF REFERRED BY A CLIENT, PLEASE LIST THEIR NAME _____

WHAT IS THE NATURE OF YOUR VISIT? _____

MEDICAL HISTORY

MEDICAL CONDITIONS
(please check all that apply, and describe if necessary)

history of facial or cold sore or genital herpes

use of blood thinner, aspirins, or NSAIDS

HIV or exposure to a person with HIV

hepatitis or known exposure to hepatitis A, B, or C

Acutane use in the past 6 months

connective tissue disorder or autoimmune disease

use of Retin-A, Retinol, Hydraquinone, or skin thinners

epilepsy or seizures

history of stroke

problem scarring

advised to have or had psychiatric care

other conditions we should know about (please describe) _____

PLEASE LIST ANY MEDICATIONS, VITAMINS, OR HERBAL SUPPLEMENTS YOU ARE TAKING. _____

PLEASE LIST ANY ALLERGIES YOU HAVE. _____

ARE YOU PREGNANT OR BREASTFEEDING?
 yes no HEIGHT AND WEIGHT _____ MALE/FEMALE _____

HAVE YOU EVER HAD SURGERY? if yes, please describe _____

WHAT SKINCARE OR LASER TREATMENTS HAVE YOU HAD IN THE PAST? _____

TERMS

24 HOUR CANCELLATION POLICY
Should I cancel or miss an appointment with less than 24 hours notice, I may be charged a missed appointment fee of \$50, unless a deposit for the service has been made, in which case I will be charged the amount of the deposit.

PAYMENT POLICY
Payment is due in full upon completion of service.

I have answered all questions on this form truthfully and disclosed my medical history to the best of my knowledge.

PATIENT SIGNATURE: _____ DATE: _____