New Client Intake Form

CPP MO LLC D/B/A AesthetiCare (AesthetiCare)

NAME		DATE OF BIRTH
FULL ADDRESS: CITY STATE, ZIP CODE		
PRIMARY PHONE NUMBER	EMAIL	PHARMACY NAME & PHONE
APPOINTMENT REMINDERS:	NOTIFY ME ABOUT EVENTS & SPECIALS:	OCCUPATION
___ TEXT ___ EMAIL	___ TEXT ___ EMAIL	

	Medical History *(please check all that apply and describe if necessary)*	
	History of cold sore or genital herpes	
	Use of blood thinners, aspirin, NSAIDS	
	HIV or exposure to HIV	
	Hepatitis A, B, or C	
	Accutane use within the past 6 months	
	Connective tissue disorder or autoimmune disease (Lupus, Rheumatoid arthritis, etc.)	
	Use of Retin-A, Hydroquinone or skin thinners	
	Epilepsy or seizures	
	History of stroke	
	Problem scarring (ex: keloid, hyperpigmentation)	
	Advised to have or had psychiatric care	
	Do you smoke or vape?	
	Are you pregnant or breastfeeding?	
	Any other conditions we should know about?	

List any medications, vitamins, or supplements you are taking:

_____

List any **ALLERGIES** or write NONE:

_____

List any surgeries you've had:

_____

What skincare or laser treatments have you had in the past?

_____

How did you hear about us? If a friend referred you, please list their name so we can thank them & credit our Referral Policy!

_____

CONTINUED ON OTHER SIDE

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Please read and initial the following:

It is the goal of AesthetiCare to offer effective and proven treatments to our clients. We will do everything possible to ensure our clients see a positive outcome from their treatments. That being said, we know from years of experience that every person is unique and will respond in a unique manner to any treatment. The following should be understood before having any aesthetic treatment:

____ I understand that every person receiving aesthetic treatments will respond in a unique manner and that no degree of outcome can be guaranteed.

____ I understand that healing time is unique and will vary with all individuals.

____ I understand that it is my obligation to inform AesthetiCare of any concern I have post treatment in a timely manner.

____ I agree to meet with a member of AesthetiCare if there are any concerns about the outcome of a treatment and review before and after photography.

____ I understand that to achieve optimal results in nearly all aesthetic treatments, multiple treatments are normally required.

____ I understand that I will be required to put a deposit down on certain treatments such as Sculptra, Sofwave, Miradry, permanent makeup, Diva, etc. This deposit is refundable only if the appointment is canceled within 5 days of the treatmP.nt time. This will be discussed with me during the consultation.

24 HOUR CANCELLATION POLICY

____ If I cancel or reschedule an appointment with less than 24-hour notice, or if I fail to show up to a scheduled appointment, I may be charged a fee of $50 per scheduled half hour up to $150. If a deposit has been made, I will be charged the full amount of the deposit.

UNFORESEEN CANCELLATION

____ In the event of an unforeseen cancellation/reschedule of your appointment on our part (due to weather, illness etc.) we will use any of the provided contact methods necessary to contact you.

PAYMENT POLICY

____ Payment is due in full upon completion of service.

_____ _____

Client Name Date

_____

Client Signature

_____ _____

Witness signature Date