Forever Young Skincare - Client Intake Form

Name: _____ **Date:** _____

By completing this client profile, you will assist us in evaluating your skin condition. The information you provide will be used to determine what factors may be affecting your skin so that we may recommend the proper care.

Address: _____

_____

_____

How did you hear about us? _____

Emergency Contacts:

Option 1: _____

Option 2: _____

Diagnosis By: _____

Best Phone #: _____

Email: _____

Birthdate: _____

Age: _____

Phone #: _____

Phone #: _____

Health/Medical *(Please answer to best of your knowledge)*

Physician's name, address, and phone number: _____

Please list all medications that you take regularly. Include hormones, vitamins, etc: _____

_____

_____

_____

Please circle any health conditions which **you have had** or are **now experiencing**:

Cancer	**Pregnancy** _____	**Epilepsy**	**Seizures**	**Lupus**
Thrombosis	**Phlebitis**	**Hemophilia**	**HIV**	**Hepatitis**
Recent Illness	**Light/Photo Sensitivity**	**Heart Problems**	**Pacemaker**	**Alcoholism**
Multiple Sclerosis	**Metal Implants/Screws**	**Hormonal Disorders**	**Claustrophobia**	**Smoking**
Hypoglycemia	**Asthma**	**Thyroid Disorders**	**Muscular Conditions**	**High/Low Blood Pressure**
Diabetes	**Lack of Normal Skin Sensation**	**Recent Surgery**	**Whiplash**	**Seizures**

Allergies: _____

_____

Is there anything else you would like us to be aware of: _____

_____

Have you ever undergone treatment from a Dermatologist? · N

If yes, when? _____

What type of condition? _____

Any negative side effects? _____

Have you ever undergone treatment from an Aesthetician? · N

If yes, when? _____

What type of condition? _____

Any negative side effects? _____

Within the last month, have you taken or used any of the following?

Retin A	☐	Antibiotics	☐	Diuretics	☐
Accutane	☐	Oral Contraceptives	☐	Laxatives	☐

Have you ever undergone plastic surgery? · N

If yes, when? _____

Where on your body? _____

What information can you provide about the procedure? _____

_____

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Chris Blaylock 250-5300

skincare@alaska.com

12320 Old Glenn Hwy, Suite B, Eagle River, Alaska

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Nutrition/Diet

Check any of the following foods that you consume and indicate the amount per day:

Sugar	☐	Spicy Foods	☐	Dairy Products	☐
Salty Foods	☐	Snack Foods	☐	Meat Products	☐

Check the types of fluids that you consume daily and indicate the amount per day:

Water	☐	Juices	☐	Tea	☐
Coffee	☐	Alcohol	☐	Sodas	☐

Home Skin Care Regimen

Describe (using product brand names) how you are presently caring for your skin:

	AM	PM		AM	PM
Cleanser:			Exfoliant:		
Toner:			Serum:		
Moisturizer:			SPF Suncreen:		
Make-Up			Other:		

How many hours do you sleep per night?

How often do you exercise?

On a Scale from 1 (low) to 10 (high) how would rate your stress level?

How much sun exposure have you had?

What are your Goals and Expectations?

What is your specific concern about your skin?

How long have you noticed your condition?

Is this an ongoing or temporary condition?

What specific improvements do you wish to see?

In what time frame do you expect to reach your goals?

Have you ever received a salon/spa skin care treatment?

What were the results?

Previous aesthetic treatments- check all that apply

Botox Date:	Dermal Fillers: Restylane/Juvaderm/Sculptra Date:	Facials Date:	Laser Treatments Date:
IPL/Photorejuvenation Date:	Chemical Peels Date:	Microdermabrasion Date:	Microcurrent Date:
LED Light Therapy Date:	Oxygen Infusion Treatment Date:	Facial Waxing: Date:	Other: Date:

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Client Release

Caution: Do not perform *microcurrent* or *vacuum massage* if any of the following conditions exist: any severe health conditions, or any of the following contraindications: Cancer, Epilepsy, History of Seizures, Pacemaker, Pregnancy, Thrombosis or Phlebitis, or if the conditions are unknown to you, consult a physician.

Caution: Do not perform *microdermabrasion* applications if any of the following conditions exist: Any severe health conditions or any of the following contraindications: any contagious disease, any drug causing sun sensitivity (Tetracycline), any drug or application causing thinning of skin (Retin-A or Accutane), blood transmitted diseases (HIV, Hepatitis, Herpes), Hemophilia, or if the conditions are unknown to you, consult a physician.

Caution: Do not perform *light rejuvenation* applications if any of the following conditions exist: Any severe health conditions or any of the following contraindications: Hypersensitivity to light or "photo allergy," tendency toward photo-toxic reactions, taking of photo-sensitizing or photo-toxic medication, Cancer, Epilepsy, History of Seizures, Lupus, Pregnancy, or if the conditions are unknown to you, consult a physician.

I certify that the above statements are true and correct, and that I, ..., having been advised and fully informed by Christine Blaylock of Forever Young Skincare concerning the nature of the process proposed, to be performed by her, and hereby authorize and direct her to perform such process and perform such services as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1) I have read, understand and fully agree to the foregoing (2) Understand the caution and contraindications for each process and service proposed (3) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire (4) I hereby give my consent and authorization voluntarily and release Forever Young Skincare and its agents of any claims that I have or may have in the future in connection with the described application or service.

Client Full Printed Name	Date
Client Signature X	Date
Witness Full Printed Name CHRIS BLAYLOCK	Date
Witness Signature Chris Blaylock	Date

Office Use Only: Verbally Confirm

Cancer	
Pregnancy	
Epilepsy	
Seizures	
Lupus	
Diabetes	
Phlebitis/Thrombosis	
HIV/Herpes/Hepatitis	
Medications	
Retin A, AHA, Tetracycline, Accutane	
Pacemaker	
Other	

Check ANY that Apply

Chris
Signature

Date

Sign by the X

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