Essentials Massage & Facials

SKIN INTAKE FORM

Name: ______________________________ D.O.B: ______________________
Contact Number: ____________________ Email: ______________________________
Address: ______________________________ Apt. # ______ City/Zip: ____________________
Emergency Contact: ____________________________ Emergency Number: ____________________

HEALTH HISTORY

	Yes	No
Are you presently under the care of a doctor or dermatologist?	☐	☐
Have you had a history of skin cancer?	☐	☐
Are you taking any medications? ________________________	☐	☐
Have you undergone cosmetic surgery in the last year? ______________	☐	☐

Have you had any of the following treatments? ☐ Laser ☐ Medical Dermabrasion ☐ Chemical Peeling

	Yes	No
Do you heal easily?	☐	☐
Do you smoke?	☐	☐
Do you exercise or play sports regularly?	☐	☐
Do you wear contact lenses?	☐	☐

Do you suffer from any of the following? ☐ Migraines ☐ Allergies ☐ Claustrophobia ☐ Herpes Simplex

<u>Females</u>

Are you pregnant or trying? ☐ Yes ☐ No
Lactating? ☐ Yes ☐ No
Meopausal? ☐ Yes ☐ No

<u>Males</u>

What is your current shaving system? ☐ Wet ☐ Electric
Do you experience irritation from shaving? ☐ Yes ☐ No
Ingrown hairs? ☐ Yes ☐ No

YOUR SKIN

Skin Conditions/Concerns ☐ Normal ☐ Sensitive ☐ Dry ☐ Oil ☐ Acnetic ☐ Combo ☐ Matured ☐ Rosacea
☐ Hyper pigmentation ☐ Dullness ☐ Broken Capillaries ☐ Clogged/Enlarged pores ☐ Blackheads ☐ Milia (white bumps)
☐ Circles/Puffiness under eyes ☐ Fine lines and Wrinkles ☐ Dry Patches ☐ Scarring
Are you currently using any Retin-A or Alpha Hydroxy Acids? ________________________
What skincare line are you currently using? ______________________________

HOME CARE REGIMEN

	Yes	No
Cleanser:	☐	☐
Treating Lotion/Toner:	☐	☐
Exfoliant:	☐	☐
Mask:	☐	☐
Concentrate/Serum:	☐	☐
Day Cream/Moisturizer:	☐	☐
Night Cream:	☐	☐
Eye Contour:	☐	☐
SPF:	☐	☐

_________ I agree to the Essentials Massage & Facials 24 hour cancellation policy, and will pay the cancellation/no show fee.

I give consent to receive treatment at Essentials Massage & Facials. I understand I will be receiving a professional service from a licensed specialist. I will provide my specialist with as much background information as possible to assure maximal results. I understand any specialists at Essentials Massage & Facials will not diagnosis illness, disease, or any physical or mental disorder. I also agree there will be no liability on the practitioner's part or Essentials LLC for any services rendered.

Client Signature: ______________________________ Date: ______________

Parent/Guardian Signature: ____________________________ Date: ____________