



Arrival Time: _____

FACIAL INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____
Address: _____
City: _____ State _____ Zip _____
Cell # _____ Other # _____
Email _____ Referred By _____
Occupation _____ Date of Birth _____
How did you hear about us _____
Emergency Contact _____ Phone # _____

****Please note:** Your hour session includes 5 minutes of preparation prior to facial and 5 minutes post facial to re-dress and consult with therapist. Session is **50 Minutes Hands-On**
_____ Initial Here

MEDICAL CONDITION

Yes / No Do you have allergies? If yes, which ones? _____
Yes / No Have you had any injectables (botox, fillers, etc..) in the past? If so what was the last date? _____
Yes / No Do you currently use Accutane, Retin A, Renova, Adapalene or any other prescription skin care products? If yes, please list: _____
Yes / No Are you currently using any products that contain the following ingredients (circle all that apply):
Glycolic Acid, Lactic Acid, Exfoliating Scrubs, Hydroxy Acids, Vitamin A
Yes / No Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? If yes, how long ago? _____
Yes/No Are you currently experiencing active cold sores?
Yes / No Do you ever experience oily shine breakouts?
Yes / No Do you ever experience burning, itching sensation on your skin?
Yes / No Have you ever experienced a reaction to any skin care products?
If so, which ones? _____
Yes / No Within the last year, have you been under a dermatologist or other Physician's care?
If so for what reason(s)? _____
Yes / No Within the last 2 years, have you undergone any surgeries? If yes, please specify: _____
Yes / No Have you had any health problems past or present? If yes, please specify: _____
Yes / No Do you smoke?
Yes / No Do you exercise regularly?
Yes / No Do you follow a restricted diet?
Yes / No Do you wear contact lenses?
Yes / No Do you have metal implants, pacemaker or body piercings?
Yes / No Are you pregnant or trying to become pregnant?
Yes / No Are you taking oral contraceptives?
Yes / No Are you lactating?
Yes / No Do you experience irritation from shaving?
Yes / No Do you experience ingrown hairs?
Yes / No Are you currently having or due for your menstrual period?
Yes / No Have you started any new medication?
Yes / No Do you have any special skin problems pertaining to your face or body? If yes, please explain.

Yes / No _____
Do you ever experience flakiness and/ or tightness?
Yes / No _____
Do you wear SPF on your face? If so, which one? _____
Yes / No _____
Do you sunbathe or using tanning beds?
Yes / No _____
Do you burn easily in moderate sunlight?
Yes / No _____
Do you blush easily when nervous?
Yes / No _____
Do you have a tendency to redness?
Yes / No _____
Do you suffer from sinus problems?

Rate your level of stress on a scale of 1- 4 (1=low, 4 = high) _____

How much water do you consume daily? _____

How many alcoholic beverages do you consume weekly? _____

Please list any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly:

What skin care products are you currently using?

Cleanser: _____

Toner: _____

Exfoliator: _____

Eye Product: _____

Moisturizer: _____

Masque: _____

Other: _____

What skin type do you feel you have, oily, aging, dry, combination, sensitive, rosacea? _____

What are your skincare goals today? **Hydration** **Anti-aging** **Brightening** **Acne treatment**
Relaxation **Other:** _____

If I experience any pain or discomfort during this session, I will immediately inform the esthetician so that the session may be adjusted to my level of comfort. I further understand that esthetics should not be considered as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that licensed estheticians are not qualified to diagnose, prescribe, or treat any physical or mental illness, and nothing that is said in the course of the session given should be construed as such. Because esthetics should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Willow Massage and the Esthetician updated as to any changes in my medical profile and understand that there shall be no liability on Willow Massage and the esthetician's part should I fail to do so.

Client Signature: _____ Date: _____

Esthetician Signature: _____ Date: _____