Facial Intake Form

For the patient: The answers you'll provide in this form allow us to make the best recommendations and offer you quality skincare treatment tailored to your specific needs.

• Client Information

Full name: _____ Date of birth: _____

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Prefer not to say

Address: _____

Phone Number: _____ Email: _____

• Skin Type & Conditions

1. Which of the following applies to your skin type?

☐ Normal ☐ Dry ☐ Sensitive ☐ Oily ☐ Aging ☐ Rosacea ☐ Acne ☐ Combination

2. What areas of concern do you have regarding your skin? (please check all that apply)

☐ Breakouts/Acne ☐ Uneven skin tone ☐ Excessive oil/Shine ☐ Dull/Dry skin

☐ Broken capillaries ☐ Dehydrated ☐ Blackheads/Whiteheads ☐ Sun damage

☐ Wrinkles/Fine lines ☐ Rosacea ☐ Redness/Ruddiness ☐ Sun, brown spots

☐ Other: _____

3. How does your skin behave when you go out into the sun?

☐ Always burns ☐ Sometimes burns ☐ Never burns ☐ Usually burns ☐ Rarely burns

• Allergies & Reactions

1. Have you ever had an adverse reaction to a cosmetic product?

☐ No ☐ Yes If yes, please explain: _____

2. Are you allergic to any of the following? (please check all that apply)

☐ Cosmetics ☐ Aspirin ☐ Benzoyl Peroxide ☐ Salicylic Acid (BHA)

3. Please list any other known allergies:

_____

• Current Skincare

1. What skin care products are you currently using? (list the brands where known)

_____

2. Do you use SPF on your face?

☐ Yes ☐ No

If yes, please explain: _____

3. Have you recently used any self-tanning products or treatments?

☐ Yes ☐ No

If yes, please explain: _____

4. Have you used the following hair removal methods in the past six weeks? If yes, please check all that apply

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking

☐ Tweezing ☐ Stringing ☐ Depilatories

5. Have you seen a dermatologist within the past year?

☐ Yes ☐ No

If yes, please explain: _____

6. Do you currently use any of the products listed below?

☐ Accutane ☐ Adapalene ☐ Retin-A/ Stieva-A

☐ Isotretinoin ☐ Renova ☐ Topical vitamin C

☐ Scrub/Peel ☐ Topical vitamin A ☐ Tretinoin/Avita

☐ Other: _____

If yes, please describe how often you use the product/products: _____

_____

7. Have you ever used any prescription for skin care?

☐ Yes ☐ No

If yes, what RX was used, and when did you take it? _____

_____

• Lifestyle and environmental factors

1. How would you describe your daily diet?

- [ ] **Balanced:** I eat a variety of fruits, vegetables, proteins, and whole grains
- [ ] **High Protein:** My diet is rich in proteins like meat, fish, eggs, or plant-based proteins
- [ ] **High Carb:** I consume a lot of bread, pasta, rice, and other carbohydrates
- [ ] **Low Carb/Keto:** I limit carbs and focus on fats and proteins
- [ ] **Vegetarian/Vegan:** My diet is plant-based with no animal products
- [ ] **Fast Food/Processed:** I often eat fast food or pre-packaged meals
- [ ] **Irregular:** My meals are inconsistent or unplanned

2. How much water do you drink in a day?

- [ ] Less than 1 liter
- [ ] 1-2 liters
- [ ] 2-3 liters
- [ ] More than 3 liters

3. What is your current stress level on a scale of 1-10?

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

4. How many hours of sleep do you get on average?

- [ ] Less than 5 hours
- [ ] 5-6 hours
- [ ] 6-7 hours
- [ ] 7-8 hours
- [ ] 8+ hours

5. Do you smoke?

- [ ] Yes
- [ ] No

6. How often do you consume alcohol?

- [ ] I don't consume alcohol
- [ ] Occasionally (1-2 times a month)
- [ ] Regularly (1-2 times a week)
- [ ] Frequent (3-4 times a week)
- [ ] Daily

7. How often are you exposed to the sun?

- [ ] Rarely (less than 1 hour per week)
- [ ] Occasionally (1-2 hours a few days a week)
- [ ] Moderately (2-4 hours on most days)
- [ ] Frequently (More than 4 hours daily)

8. Have you recently received Botox, Restylane, or Collagen injections?

- [ ] Yes
- [ ] No

If yes, please specify when: _____

• FOR FEMALE CLIENTS ONLY

Do you take any oral contraceptives?

☐ Yes ☐ No

If yes, please specify: _____

Please check any of the following that apply to you:

☐ Pregnant or trying to conceive

☐ Lactating

☐ Menopause

☐ Hormone replacement therapy

• Previous treatments and reactions

1. Have you ever had any facial treatments before?

☐ Yes ☐ No

If yes, please check all that you have experienced

☐ Chemical peel ☐ Classic facial ☐ Microdermabrasion ☐ Hydra facial

☐ Acne facial ☐ Deep cleansing facial ☐ Anti-aging ☐ Dermaplaning

☐ Laser ☐ Collagen induction therapy

☐ Other (please specify): _____

2. Have you ever experienced an adverse reaction to a skincare product or treatment?

☐ Yes ☐ No

If yes, please specify: _____

_____

3. Do you have a history of scarring or difficulty healing after skin treatments?

☐ Yes ☐ No

If yes, please specify: _____

_____

• Consent to treatment and photography

1. Do you understand the risks and benefits of the treatment being performed?

☐ Yes ☐ No

2, Do you consent to proceed with the recommended treatment?

☐ Yes ☐ No

3. Do you agree to have before-and-after photos taken for medical records?

☐ Yes ☐ No

4. Do you consent to using your photos for marketing purposes, such as social media or promotional materials?

☐ Yes ☐ No

5. Do you have any additional questions or concerns before proceeding with the treatment?

☐ Yes ☐ No

If yes, please add your questions here: _____

_____

• Emergency contact information

Who should we contact in case of an emergency? *(Add full name)*

_____

Their relationship to you: _____ Their phone number: _____

• Acknowledgment & Release

By signing this form, the client agrees to the following:

I confirm that I have completed this questionnaire truthfully and will inform the technician of any changes.

This form represents full disclosure and overrides any previous disclosures. I understand that withholding or misrepresenting information may lead to skin irritation or contraindications.

The treatment I receive is voluntary, and I release this clinic and its professionals from liability, assuming full responsibility.

• Client signature

Client name (printed): _____

Client signature: _____

Date: _____