

Intake Form:

Name: _____ Date: _____ DOB _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home phone number: _____ Cell number _____

Email address: _____

How did you hear about us? _____

Referred by: _____

Allergies: _____

Current medications, including over the counter

Your primary Doctor _____

Injuries/Accidents/Illnesses _____

Surgeries _____

Facial and Massage Clients Only

Are there any areas that you DO NOT want massaged?

_____yes _____ no if yes, please list _____

Have you had a massage before? _____ Do you prefer light medium or deep
massage _____

How do you tan? Burn easily__ First burn then tan __ Tan, rarely burn __
Always tan__

Do you use sun protection? Rarely __ Sometimes __ Always__

I consider my skin type to be:

Oily __ Dry__ Sensitive __ sun damaged__ Combo__ Aging__

Prior Experience with Medical Spa Treatments? __ yes __ no

If yes, please list _____

Continue on reverse

Medical spa clients please fill out: Medical History:

Do you have a history of: please write yes or no

Bleeding Disorder: _____ Endocrine/Hormone issues: _____

Pigmentation disorder: _____ Pacemaker/defibrillator: _____

Cold sores: _____ Acutance within 6 months: _____ Keloid scarring: _____

Current or history of cancer: _____ Dermatological conditions: _____ Very dry

skin: _____ Active Infection: _____ Exposure to sun/artificial tanning 1 weeks

prior _____ Bleeding Coagulopathies, or use anticoagulants: _____

Use of photosensitive medication and/or herbs that may cause sensitivity to 515nm – 1200 nm light exposure, such as Isotretinoin(Retin A), tetracycline, or St. John's Wort _____

List previous types of laser procedures (photofacial, vein, hair removal, acne, rosacea, hyperpigmentation, etc.):

CONTRAINDICATIONS:

Pacemaker of internal defibrillator *Accutane taken in last 6 months* History of keloid scarring *Atypical moles or malignancy*

Non-intact skin (i.e. sores, psoriasis, eczema, infection, rash) should be avoided

Any medical condition involving impairment of skin structure, esp. healing patterns Poorly controlled diabetes *Pregnancy*

PRECAUTIONS:

Medications that may cause photosensitivity to light 540 – 950 nm

Impaired healing

All the information provided herein remains confidential and your email is not disclosed but used for communication to inform you of special events and discounts. **We look forward to making you look and feel your best.**

All appointments are secured with a credit card. Any appointment not cancelled or rescheduled prior to 48 hours notice will result in the full charge for the service booked. No refunds are given for services rendered or

products sold. If you are dissatisfied for any reason please notify us within 48 hours of your appointment to discuss.

I have completed this form to the best of my knowledge and will inform my therapist if any change in my medical condition occurs.

Signature _____ Witness _____ Date _____