


Esthetician Client Intake Form

Client Information			
First Name	Last Name	Date of Birth	Gender
Address		City	State Zip Code
Email		Preferred Phone Number	
Emergency Contact			
Full Name	Relationship	Contact Number	
Full Name	Relationship	Contact Number	
Medical History			
Please list any medical conditions or health problems you have had in the past or present.			
Please list any medications you use regularly, including any supplements, vitamins, accutane, or other skin care medications.			
Do you have any allergies, including to any cosmetics, latex or medicines? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify:			
Have you been under the care of a dermatologist or other physician within the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:			
Skin Care History			
Do you use or have you used in the last 3 months Retin-A, Renova, AHA's, or Retinol/Vitamin A derivative products? If yes, please describe: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had chemical peels, microdermabrasion, or resurfacing treatments in the past month? If yes, please describe: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you received Botox, Restylane, or Collagen injections in the last 6 months? If yes, please specify: <input type="checkbox"/> Yes <input type="checkbox"/> No			
What is your skin type? <input type="checkbox"/> Normal <input type="checkbox"/> Dry <input type="checkbox"/> Oily <input type="checkbox"/> Combination			
What are your specific concerns/challenges for your skin?			
I confirm that the answers I have given are correct to the best of my knowledge and that I have not withheld any information that may be relevant to my treatment.		 Signature	 Date