Facial Intake Form

Name	Date
Phone number	Email
Address	
Emergency contact person	Phone number
Skin History	

Do you have any skin allergies?

☐ Yes

☐ No

    (If yes, please specify): _____

Have you ever had any adverse reactions to facial products or treatments?

☐ Yes

☐ No

    (If yes, please specify): _____

Are you currently using any prescription skincare products?

☐ Yes

☐ No

    (If yes, please specify): _____

Do you have any existing skin conditions (acne, rosacea, eczema, etc.)?

☐ Yes

☐ No

    (If yes, please specify): _____

Have you had any recent cosmetic procedures (Botox, fillers, chemical peels, etc.)?

☐ Yes

☐ No

    (If yes, please specify): _____

Health history

Are you pregnant or breastfeeding?

☐ Yes

☐ No

Do you have any medical conditions we should be aware of?

☐ Yes

☐ No

(If yes, please specify): _____

Are you currently taking any medications?

☐ Yes

☐ No

(If yes, please specify): _____

Have you ever had a history of skin cancer?

☐ Yes

☐ No

Have you had any recent surgeries or medical procedures?

☐ Yes

☐ No

(If yes, please specify): _____

Skincare routine

Describe your current skincare routine (cleanser, moisturizer, sunscreen, etc.):

_____

_____

How often do you cleanse your face?

_____

_____

How often do you exfoliate your face?

_____

_____

Do you use any retinol or acids in your routine?

☐ Yes

☐ No

Do you use sunscreen daily?

☐ Yes

☐ No

Treatment preferences

What specific facial concerns would you like to address?

_____

_____

Have you had professional facials before?

☐ Yes

☐ No

What type of facial treatment are you interested in (e.g., hydrating, deep cleansing, anti-aging, etc.)?

_____

_____

Do you have any preferences or restrictions on the products used during the facial?

_____

_____

Are you interested in additional treatments such as extractions, masks, or massage?

_____

_____

Additional notes

Acknowledgment

I understand that the esthetician will analyze my skin and recommend treatments/products based on my skin concerns and health history. I consent to these recommendations and understand that results may vary.

I confirm that the information provided above is accurate to the best of my knowledge.

Signature over printed name	**Date**