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INTAKE + CONSENT

Personal Information

Full Name _____ DOB _____

Sex: Female _____ Male _____ Prefer Not To Answer _____

Street _____ City _____ State_____ Zip_____

Cell No. _____ Email _____

How did you hear about us? _____

Emergency Contact/Number/Relationship To Patient

_____

Health History + Helpful Information

Have you previously had OR are you presently experiencing any of the following?

___ Heart Condition
___ Stroke
___ Cancer
___ Osteoporosis
___ Seizures/Epilepsy
___ Low/High Blood Pressure
___ Claustrophobia
___ Hemophilia
___ Back Problems
___ Pace Maker
___ HIV
___ Hepatitis
___ Edema/ Thrombosis
___ Pregnant/Lactating
___ Varicose Veins
___ Arthritis
___ Diabetes
___ Hyper/Hypo Thyroid
___ Seborrhea
___ Lupus
___ Acne
___ Recurrent Headaches
___ Seasonal Allergies
___ Hyper Pigmentation
___ Hypo Pigmentation
___ Rashes
___ Shingles
___ Eczema
___ Fever Blisters
___ Psoriasis
___ Rosacea
___ Skin Cancer
___ Asthma
___ Sinusitis
___ Insomnia

___ Cold/Infection ___ Anaphylactic Reactions

___ Digestive Problems ___ Other:_____

Have you been experiencing symptoms of COVID-19 or been around anyone who has symptoms in the last 48 hours? Have you or anyone around you tested positive for COVID-19 in the past 48 hours? NO _____ YES _____ (If yes, please explain below.)

_____

_____

_____

Are you currently on any medications? Please list.

_____

_____

_____

_____

Have you had an injury or operation in the last two years? Please specify.

_____

_____

_____

Have you had any recent cosmetic surgery or spa facial treatments? Please specify.

_____

_____

_____

Are you allergic to latex or any medications/products? If so, please list and explain.

_____

_____

_____

_____

Is there anything else you think we should know?

_____

_____

Which of the following best describes your skin type. Please choose one.

____ Type I- Fair skin tones: Always burns, never tans

____ Type II- Light skin tones: Burns easily, tans slightly

____ Type III- Fair to olive skin tones: Burns moderately, tans moderately

____ Type IV- Light brown skin tones: Burns slightly, tans easily

____ Type V- Dark brown skin tones: Rarely burns, tans easily

____ Type VI- Dark brown to black skin tones: Never burns, tans easily

Would you like to find relief or see an improvement in any of the following areas?

___ Breakouts/Acne
___ Sun Damage
___ Rosacea
___ Uneven Skin Tone
___ Excessive Oil/Shine
___ Dull/Dry Skin
___ Flaky Skin
___ Sun/Liver/Brown Spots
___ Redness/Ruddiness
___ Blackheads/Whiteheads
___ Wrinkles/Fine Lines
___ Broken Capillaries
___ Dehydrated Skin
___ Ingrown Hair

Is there anything else you would like to focus on today? What is your main concern?

_____

_____

_____

What skin care products are you currently using? List brands if you know.

Cleanser _____

Day Moisturizer _____

Night Moisturizer _____

Toner _____

Exfoliator _____

Eye Product _____

Scrubs _____

Soap _____

Body Lotion _____

Mask _____

SPF _____

Makeup _____

Shower Gels _____

Other _____

Have you recently used any self-tanning lotions, creams, or treatments?

YES ____ NO____ (If yes, please explain) _____

Have you had any recent tanning bed or sun exposure that changed the color of your skin?

YES ____ NO____ (If yes, please explain) _____

Are you now or have you ever used Accutane?

YES ____ NO____ (If yes, please explain) _____

Are you presently using (or used in the past) Azlex, Differin, Renova, Retin-A or Hydroxy Acids?

YES ____ NO____ (If yes, please explain) _____

Have you received Botox®, Restylane® or collagen in the last 6 months?

YES ____ NO____ (If yes, please explain) _____

Do you wear contact lenses?

YES ____ NO____

Do you smoke?

YES ____ NO____. (If yes, please explain) _____

Female Clients

Are you taking oral contraceptives?

YES ____ NO____ (If yes, please explain) _____

Any recent changes to or from your contraceptive treatments?

YES ____ NO____ (If yes, please explain) _____

Are you pregnant or trying to become pregnant?

YES ____ NO____ (If yes, please explain) _____

Are you experiencing any menopausal symptoms?

YES ____ NO____ (If yes, please explain) _____

Are you undergoing any hormone replacement therapy treatments?

YES ____ NO____ (If yes, please explain) _____

Male Clients

Do you experience irritation from shaving?

YES ____ NO____ (If yes, please explain) _____

Do you experience ingrown hairs as a result of hair removal?

YES ____ NO____ (If yes, please explain) _____

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WAXING INTAKE
(if applicable)

What are we waxing today?

Face & Brows

___ Brow Shape

___ Lip

___ Chin

___ Full Face

___ Sideburns

___ Brow & Lip

Upper Body

___ Full Arms

___ Half Arms

___ Underarms

___ Back/Shoulders

___ Abdomen

___ Chest

Lower Body

___ Full Legs

___ Half Legs

Other

___ Brazilian- Full

___ Brazilian- Shape

___ Bikini

___ Full Body

Do you take or use any products that contain the following:

___ Isotretinoin ___ Retinoic Acid ___ Hydroquinone

___ Tetracycline ___ AHA Glycolic Acid

Have you recently had any type of chemical or glycolic peel?

YES ____ NO____

If glycolic, what percentage? _____

If chemical, please explain: _____

Any recent surgery or dermabrasion?

YES ____ NO____ (If yes, please explain) _____

Any skin cancer or removal of skin cancer?

YES ____ NO____ (If yes, please explain) _____

Are you on your menstrual cycle?

YES ____ NO____

How would you rate your sensitivity to pain?

___ Low ___ Medium ___ High

Do you have any moles, warts, abrasions, skin irritations or skin inflammations in the areas to be waxed? YES ____ NO____ (If yes, please explain) _____

Do you have skin lesions?

YES ____ NO____ (If yes, please explain) _____

Do you have Eczema or Rosacea?

YES ____ NO____ (If yes, please explain) _____

Have you been exposed to any tanning method in the last 24 hours?

YES ____ NO____ (If yes, please explain) _____

Have you taken any blood thinners, aspirin, or any anti-coagulating medication within the last 24 hours? YES ____ NO____ (If yes, please explain) _____

Have you been waxed before?

YES ____ NO____ (If yes, please explain) _____

If yes, did you suffer any adverse reactions?

YES ____ NO____ (If yes, please explain) _____

When did you last shave? _____

How often do you shave? _____

Future Appointments/Contact

How would you like to be contacted to confirm future appointments?

Would you like to receive information about future promotions and news?

YES ____ NO____

Treatment Consent

I understand, have read and completed this intake form truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information and providing misinformation may result in contraindications and/or irritations to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/professional and assume full responsibility thereof.

Cancellations

We request a minimum of 24 hours notice for cancellation of any scheduled appointments to avoid any unnecessary charges . 50% of your scheduled services will be charged to the card on file without a 24 hour notice and full price of your scheduled appointment if no notice is given. Late arrivals may result in a reduced or canceled service.

Client Printed Name: _____

Client Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact our office.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemails, emails, texts, postcards, or letters).

The undersigned have read and understood the Notice of Privacy

Authorized signature of covered person (For minor, Parent or Guardian)

Patient Printed Name _____

Patient Signature _____ Date _____