Hands On Healing Spa 512.796.6399
Handsonhealingspa.com

Facial Intake

Name: _____ Date: _____

Emergency Contact: _____ Phone: _____

Does your job require you to work outdoors? **YES** **NO**

What would you like to achieve from your treatment today? _____

Your Skin Care

Have you ever had a facial treatment before? **NO** **YES** When? _____

Which of the following best describes your skin type? (Please circle one type number)

I	**Cream complexion**	**Always burns easily, never tans**
II	**Light complexion**	**Always burns, tans slightly**
III	**Light/Matte complexion**	**Burns Moderately, tans gradually**
IV	**Matte complexion**	**Seldom burns, always tans well**
V	**Brown complexion**	**Rarely burns**
VI	**Black complexion**	**Never burns, deeply pigmented**

Do you have any special skin problems or concerns pertaining to your face or body? **YES** **NO**

Specify: _____

Have you ever had chemical peels, laser or microdermabrasion? **NO** **YES** In the last 30 days? **NO** **YES**

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products, Deferin, Glycolic Acid, AHA, Salicylic Acid? **NO** **YES** Describe: _____

Have you used any of these products in the last 3 months? **NO** **YES**

Have you used an acne medication? **NO YES** When?_____ Which Drug?_____

What skin care products are your currently using? (list brand where known)

Soap	**Toner**	**Scrubs**
Body Lotion	**Mask**	**Sunscreen**
Eye Product	**SPF**	**Cleanser**
Night Moisturizer/ Cream	**Day Moisturizer**	**Exfoliator**
Make up products		

Have you recently used any self-tanning lotions, creams or treatments? **NO** **YES** _____

Have you used any of the following hair removal methods in the past six weeks? **NO** **YES**

Shaving **Waxing** **Electrolysis** **Plucking** **Tweezing** **Stringing** **Depilatories**

What areas of concern do you have regarding your skin: (Please circle all that apply and explain)

Breakouts/ acne **Uneven skin tone** **Blackheads** **Whiteheads**

Sun Damage **Excessive oil/shine** **Wrinkles/fine lines** **Rosacea**

Dull/dry skin **Broken Capillaries** **Flaky Skin** **Dehydrated**

Sun/liver/brown spots Other: ____

Eyes: Dehydrated Wrinkles Puffiness Dark Circles **Lips:** Dehydrated Cracked/ Chapped Lips
Other:________________________________

Have you ever had an allergic reaction to any of the following?

Cosmetics **AHA** **Medicine** **Food** **Fragrance** **Pollen**

Shellfish **Animals** **Latex** **Drugs** **Iodine**

If yes explain: ____

What SPF do you use on your face? ___________ How often/when? __________________

What SPF do you use on your body? __________________ How often/when? ___________

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

NO **YES** Specify:____

Have you experienced Botox, Restylane, or Collagen injections? **NO** **YES**

Specify: ____

Female Clients Only:

Are you taking oral contraceptives? **NO** **YES** specify: _____________________
Any recent changes to or from your contraceptive treatment: **NO** **YES** If yes what and when:
Are you pregnant or trying to become pregnant? **YES** **NO**
Are you lactating? **NO** **YES**
Any menopause problems? **NO** **YES** Specify: ________________________
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Male Clients Only:

What is your current shaving system? Wet Shave ☐ Electric ☐
Do you experience irritation from shaving? **NO** **YES** Ingrown hairs? **NO** **YES**
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Have you been under the care of a physician, dermatologist or other medical professional within the past year? **YES** **NO** explain: ____

Any recent surgery, including plastic surgery? **NO** **YES** explain: ____________________

Any Skin cancer? **NO** **YES** explain: ____

Have you had any piercings, tattoos, or permanent cosmetics? **NO** **YES** If yes, where on your person? _
____

Please circle all that apply past or present:

Cancer Hormone Imbalance Headaches Hepatitis

Systemic disease Herpes Frequent Cold Sores Eczema

Keloid scarring **Fever Blisters** **Skin disease/skin lesions** **Active infection**

Any concerns about raising body temperature? **NO YES** Do you smoke? **NO YES**

Do you follow a restricted diet? **NO YES** What is your stress level? **HIGH MEDIUM LOW**

Do you follow a regular exercise program? **NO YES**

Do you form thick or raised scars from cuts or burns? **NO YES**

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after a physical trauma? **NO** **YES** describe: _____

List your daily consumption of: **Water** **Caffeine** **Alcohol**

Do you experience in trouble sleeping? **NO** **YES** How many hours? _____

Do you wear contacts? **NO YES** Do you have any metal implants or wear a pacemaker? **N Y**

Have you been exposed to the sun or used a tanning bed in the last 48 hours? **NO YES**

How frequently are you exposed to the sun/tanning bed? **___Infrequently ___ Frequently __ Regularly**

Have you ever experienced claustrophobia? **NO YES** Do you suffer from sinus problems? **NO YES**

Have you ever had an adverse reaction after using any skin care products?

Rash **Irritation** **Peeling** **Sun Sensitivity** **Breakout**

Appointments/Contact: May I contact you about your services today to check in? **YES NO**

Best way to make contact phone, text, or email? _____ Best Time: **AM** **PM**

I understand, have read, and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health and/or skin care professional from liability and assume full responsibility thereof.

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved.

I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at and additional cost.

I have read and understand the post-treatment care instructions. I understand how important it is to follow all instructions given to me for post treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I do not hold the esthetician responsible for any of my condition that were present, but not disclosed at the time of this skin care procedure, which may be affected by treatment performed today.

Client Name: (Printed)_____

Client Name (Signature)_____ Date:_____