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? ___________________________

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?_______________

Please check skin care products you are currently using: (list brand where known)

___ Cleanser ___ Toner ___ Serum ___ Scrub ___ Mask ___Eye Cream ___Moisturizer

___ Sunscreen ___ Self Tanner ___ Concealer ___ Make-Up ___Other: _______________

Anything Else We should Know?

____

____

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**

Bumps **Facial Veins** **Large pores** **Body Acne**

Under Eye Puffiness/Dark Circles **Acne Scarring** **Cysts/Nodules**

Excessive Facial Hair **Melasma/Brown Spots/Patches** **Frequent Break Outs**

Cellulite **Dull Complexion** **Loss of Lashes/Brows** **Redness**

Sagging Skin **Sun/liver/brown spots** Other: ____________________________

Are you in good overall health? **YES** **NO** Explain: ___________________________________

____

Are you currently under the care of a physician? **YES** **NO** Explain: _________________________

Do you have any allergies to foods or medications? **YES NO** Explain: ___________________

Are you currently on any medications either topical or oral? **NO YES** ________If Yes please list:______

Ethnic Background (Parents, Grandparents, Great Grandparents):

How do you heal after an acne breakout, cut or scratch? **No Scar Red Brown**

Do you smoke? **NO YES** Are you prone to cold sores? **YES NO**

Date of last sore:____

Do you have an allergy to latex: **YES NO** What is your stress level? **HIGH MEDIUM LOW**

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

Specify: ____

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**

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 it is my responsibility to inform the esthetician/skin care therapist of my current medical and/or health medical conditions and do not hold my service provider liable for information that has not been disclosed.

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 understand 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:_______________