# CLIENT INTAKE FORM - FACIAL

Name_______________________________ Date of birth: _______________________

City: _______________ State: __________ Zip: __________ Age: _______________ Male Female

Occupation: _______________________________ Referred by: _______________________

Is this your first facial? Yes No

If No, when was your last Facial? _______________________

What did you enjoy most? _______________________ What did you NOT like? _______________________

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Please take a moment to answer the following questions.

1 What is your main concern with your skin? _______________

2. What results do you expect from your service? _______________

_______________________

3. Are you presently under a physician's care for any current skin condition or other problem? Yes No

4. Are you pregnant? Yes No

5. Are you taking birth control pills? Yes No

   If "Yes", what type? _______________________

6. Are you presently using (or used in the past) Azlex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alpha Hydroxy Acids?
   Yes No

   If "Yes", when and for how long? _______________________

   _______________________

7. Are you now using or have you ever used Accutane?
   Yes No

**Do you Tan or Burn?** _______________________

8. Are you presently taking any medications? Yes No

   If so, please list _______________________

   _______________________

9. Do you wear contact lenses? Yes No

10. Do you smoke? Yes No

11. Do you have any allergies to cosmetics, food or drugs?
    Yes No

    If so, please list _______________________

    _______________________

12. Have you had skin cancer? Yes No

    If so, what? _______________________

13. Do you often experience stress? Yes No

14. What skin car products do you use presently? _______________

    _______________________

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Please check if you are affected by or have any of the following:

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|---|---|---|---|---|
| Asthma | Fever blisters | Hysterectomy | Sinus Problems | Metal bone, pins, or plates |
| Cardiac Problems | Headaches-chronic | Skin Disease | Immune Disorders | |
| Depression | Anxiety | Hepatitis | Lupus | |
| Herpes | Epilepsy | High Blood Pressure | Pace Maker | |
| | | | Eczema | |

Please explain above problems or list any other significant issues. _______________________

## Please list any and all allergies:

_______________________

I understand that the services offered are not a substitute for medical care; and any information provided by the therapist, is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

**Cancellations**:
We request a minimum of 24 hours notice for cancellations of any scheduled appointments or a minimum of 48 hours for a group cancellation to avoid any unnecessary changes. 50% of your scheduled services will be required without a 24 hour notice, and full price of your scheduled appointment will be required if no notice has been given. Late arrivals may result in reduced or cancelled service.

Client Signature _______________________________ Date _______________

**Consent to Treatment of Minor:** By signature below, I hereby authorize _______________________ to Administer massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.
Signature of Parent or Guardian:

_______________________________ Date_______________

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**esSpa Organic Hungarian Skincare + Salon - 17 Brilliant - PGH, PA 15215 - (412) 782-3888**