CONFIDENTIAL SKIN CARE HISTORY

FACIAL & SKIN CARE INTAKE FORM

Welcome to the place to relax! We are grateful for the opportunity to work with you.
Please let us know if you have any questions or concerns regarding your visit.

PLEASE PRINT CLEARLY **TODAY'S DATE: _____**

_____ _____

LAST NAME **FIRST NAME** **MIDDLE INITIAL** GENDER / PRONOUNS OPTIONAL

_____

Mailing Address City State ZIP

_____

Email Address ***(REQUIRED** for contact-less checkout, appointment notifications, updates, specials, etc.)*

_____

○ Home Phone ○ Mobile Phone ○ Work Phone

SELECT PREFERRED CONTACT: ○ Home Phone ○ Mobile Phone ○ Work Phone ○ Email

_____ _____ ✓_____

Date Of Birth Age Parent / Guardian Signature + Printed Name & Relationship *(Required If Under 18)*

_____

Occupation Employer

_____

EMERGENCY CONTACT (Name & Relationship) Phone

How did you hear about us? ○ Existing Client ○Gift Certificate ○Social Media
○Medical Referral / Other: _____

IS THIS YOUR FIRST FACIAL? ○ Yes ○ No How long since your last facial? _____

Do any of the following apply to you TODAY?
○ Cold sores or fever blisters ○ Open cuts, bruises, burns ON FACE ○ Cold or flu symptoms / fever ○ Sunburn
○ Irritated skin or rash ON FACE ○ OTHER: _____

Which of the following best describes your skin type?
○ Sensitive ○ Dry ○ Combination ○ Oily ○ Very oily / large pores ○ Oily in T-zone, dry to normal cheeks

Do you have any allergies or sensitivities?
○ NO ○ YES, EXPLAIN: _____

HEALTH HISTORY OVERVIEW

1. Have you been under the care of a physician, dermatologist or other medical professional within the past year?
   ○ NO ○ YES, explain: _____
2. Have you had any recent injections (Botox, fillers, etc.) or surgery, including plastic surgery?
   ○ NO ○ YES, explain: _____
3. Have you ever had skin cancer?
   ○ NO ○ YES, explain: _____

4. Do you have any permanent cosmetics?
   ○ NO ○ YES, explain_____

5. Have you ever had a facial or body spa treatment before?
   ○ NO ○ YES, When? _____

6. Are you pregnant or nursing? ○ NO ○ YES: Due / Delivery date: _____
   Prenatal caregiver / physician: _____

7. List any prescription AND over the counter medications you take regularly:
   _____

8. Do you use Retin-A, Renova, Adapalene, Differin, Tretinoin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products?
   ○ NO ○ YES, explain: _____

9. Have you ever used any prescription acne medication?
   ○ NO ○ YES, explain: _____

10. Have you been exposed to the sun or used a tanning bed in the last 48 hours?
    ○ NO ○ YES, explain: _____

11. Have you ever had an adverse reaction after using any skin care product?
    ○ Rash ○ Irritation ○ Peeling ○ Sun sensitivity ○ Breakout ○ Other: _____

DO YOU NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING HEALTH CONDITIONS?

○ Arthritis
○ Asthma
○ Blood clotting abnormalities
○ Cancer
○ Diabetes
○ Eczema
○ Epilepsy
○ Fever blisters
○ Frequent cold sores
○ Headaches (chronic)
○ Heart problems / conditions
○ Hepatitis
○ HIV/AIDS
○ Hormone imbalance
○ Hysterectomy
○ Keloid scarring
○ Lupus
○ Metal bone pins or plates
○ MRSA
○ Neck pain
○ Psoriasis
○ Rosacea
○ Seizure disorder
○ Skin disease / skin lesions
○ Spinal injury
○ Staph infection
○ Systemic disease
○ Telangiectasia / Couperose
○ Thyroid condition
○ Other: _____

APPOINTMENT POLICY

- **A CREDIT CARD on file is required to HOLD all appointments**. A 50% DEPOSIT is required for all appointments booked online. A 50% DEPOSIT may also be required for groups, couples, and other appointments.
- We require **24-HOURS NOTICE to cancel or reschedule** an appointment. Failure to honor this policy will result in a **CANCELLATION FEE of 50%** of the value of your service -- as well as require a 50% deposit for future appointments.
- Neglecting to call us to cancel an appointment will result in a **NO SHOW FEE of 100%** of the value of your service, payable before any future appointment can be booked – as well as requiring 50% deposit for all future appointments.

ACKNOWLEDGEMENT

I confirm that the information provided herein is true and accurate to the best of my knowledge. I understand that a facial is not a substitute for medical care and that no diagnosis will be made. I give consent for the use of my confidential health Information for the specific purpose of providing treatment to me and for general administration operations of Bodyworks Massage Center Inc. (BMC). **I have read, understand, and agree to abide by the terms of BMC's "APPOINTMENT POLICY" as shown above and understand that payment is due when services are rendered and in compliance with said policy.**

✓_____ _____
Signature Date