Client Intake Form

Name: _____ Date:_____
Last First

Address: _____ City: _____ST:_____ Zip:_____

Email: _____ Phone: _____

How did you hear about Skin Renew Day Spa? _____
What are your main concerns? _____
How long have you been experiencing your current condition? _____
Have you had any injuries or surgeries that may affect today's treatment? _____

What service(s) are you interested in? Please check all that apply.

- ☐ Waxing
- ☐ HydraFacial
- ☐ Facials
- ☐ Lash Extensions
- ☐ Tattoo Removal
- ☐ Skin Tightening
- ☐ Age/Sun Spots
- ☐ Acne Scarring
- ☐ Rosacea
- ☐ Stretch Marks
- ☐ Acupuncture
- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Facial Acupuncture
- ☐ Myofascial Release
- ☐ Therapeutic Message
- ☐ Other: _____

Please check the products that you currently use and list the brand names:

- ☐ Cleanser _____
- ☐ Sunscreen _____
- ☐ Eye Cream _____
- ☐ Moisturizer _____
- ☐ Exfoliant _____
- ☐ Vitamin A _____
- ☐ Vitamin C _____
- ☐ Other _____

What is your skin type?

☐ Dry ☐ Combination ☐ Oily ☐ Normal

Are you using any tropical creams or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? If so, please list them. _____

Have you ever had any of the following wrinkle fillers or facial implants?

☐ Collagen ☐ Restylane ☐ Hylaform ☐ Juvaderm
☐ Silicone ☐ Radiesse ☐ Perlane ☐ Sculpta

Other _____If so, when? _____ What area? _____ By whom? _____

Have you ever undergone any of the following treatments?

☐ Cosmetic Surgery
If so, when? _____ What area? _____ By whom? _____
☐ Botox
If so, when? _____ What area? _____ By whom? _____
☐ Chemical Peel
If so, when? _____ What area? _____ By whom? _____
☐ Accutane
If so, when? _____ What area? _____ By whom? _____
☐ Microdermabrasion
If so, when? _____ What area? _____ By whom? _____
☐ Laser Treatment
If so, when? _____ What area? _____ By whom? _____

Medical History

This information is necessary for your procedure. Please answer the following questions:

Are you using any prescribed medications?	☐ No	☐ Yes_____
Are you using any light-sensitive medications?	☐ No	☐ Yes_____
Do you take oral anti-coagulant (blood thinning) meds?	☐ No	☐ Yes_____
Are you using any Herbal medications?	☐ No	☐ Yes_____
Do you have ALLERGIES to any cosmetic ingredients, medications or foods?	☐ No	☐ Yes_____
Are you pregnant or trying to become pregnant?	☐ No	☐ Yes
Are you breastfeeding currently?	☐ No	☐ Yes
Do you use oral contraceptives?	☐ No	☐ Yes
Do you use hormone replacement therapy?	☐ No	☐ Yes
Do you smoke?	☐ No	☐ Yes
Do you use tanning beds?	☐ No	☐ Yes
Do you have any tattoos or permanent makeup?	☐ No	☐ Yes

Notes: _____

Please check any health problems, past or present:

☐ Seizures/Epilepsy	☐ Heart problems	☐ PCOS
☐ Thyroid	☐ Hepatitis	☐ High Blood Pressure
☐ Hormonal Problems	☐ Cancer	☐ Asthma
☐ Autoimmune	☐ Vasovagal Syncope	☐ Sarcoidosis
☐ Diabetes	☐ Skin Cancer	☐

Do you have any of the following chronic skin disorders (check all that apply)?

- ☐ Psoriasis
- ☐ Dermatitis
- ☐ Eczema
- ☐ Vitiligo
- ☐ Melasma
- ☐ Herpes Simplex/Blisters
- ☐ Keloid Scarring
- ☐ Fever Blisters
- ☐ Cystic Acne
- ☐ Cold Sores
- ☐ Other: _____

In addition to the above, please tell us which conditions concern you most (check all that apply):

- ☐ Acne
- ☐ Scarring
- ☐ Sun Damage
- ☐ Unwanted Hair
- ☐ Pimples
- ☐ Sun Spots
- ☐ Clogged Pores
- ☐ Uneven Skin Tone
- ☐ Wrinkles
- ☐ Dry patches
- ☐ Enlarged Pores
- ☐ Excessive Oiliness
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Upper Lip Lines
- ☐ Hard Bumps Under Skin
- ☐ Brown Spots
- ☐ White Spots
- ☐ Blood Vessels
- ☐ Other: _____

Client Name (printed) _____

Client Name (signature) _____ Date _____

Skin Renew Day Spa Staff: _____ Date _____

Client Consent Form

I hereby consent to and authorize Skin Renew Day Spa & Laser Center to perform the following procedure(s):

____ Facial ____ Waxing ____ Mani/Pedicure ____ Other: _____

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

Although it is impossible to list every potential risk and complication, 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. I also recognize that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. If I may have additional questions or concerns regarding my treatment or suggested home product or post-treatment care, I will consult the Skin Renew Day Spa staff immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies, prescription drugs or topical products I am currently using.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the Skin Renew Day Spa staff, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____ Date _____

Skin Renew Day Spa Staff _____ Date _____

Use/Disclosure of Health Information

I authorize Skin Renew Day Spa to communicate with me via email, text or phone reminders prior to my appointments at Skin Renew Day Spa at the contact information provided to Skin Renew Day Spa. This form requests you to advise: (A) *to whom we may disclose information* (B) *the reason for disclosure*, and (C) *the information to be disclosed.* However, to further protect your right to privacy, Skin Renew Day Spa *will not use or disclose* health information to family members, doctors, insurance companies, health insurance companies or to any other entities *without a current written authorization at the time the information is to be released.* Skin Renew Day Spa may discuss your health and/or treatment with/will provide your information to:

I, _____, hereby authorize the disclosure of my health and/or treatment information from my records to:

Name: _____
Address: _____
City/State/Zip: _____

The information I authorize to be disclosed from my health/treatment record: (initial appropriate boxes)

____ Entire Record ____ Visit Notes ____ Health & Physical ____ Medication or Problem List ____ Billing

Only information related to: _____

Please sign below to acknowledge you have read and agree with this policy.

_____
Client Signature

_____
Date

Photography Consent

Photographs may be taken at each visit by Skin Renew Day Spa & Laser Center for clinical purposes to evaluate and assess treatment. I hereby give Skin Renew Day Spa & Laser Center permission to use my photographs in the following manner.

☐ Unrestricted use of photograph (this may include website and social media)

Please check all that apply for restricted uses:

☐ Use only photographs in which my identity is concealed.

☐ Use in the office "Lookbook" to show other patients about procedures.

☐ Use in new patient consultations to teach other patients about procedures.

☐ Use in professional writing, which may include textbooks, journals, newsletters, etc.

☐ None of the above. Please do not use my photographs for any purpose.

Please sign below to acknowledge you have read and agree with this policy.

Client Name _____

Client Signature _____ Date _____

Cancellation Policy

Our staff hours are limited and valuable.

Missed appointments, being late more than 10 minutes or failure to give a 24-hour notice of cancellation or rescheduling will result in a $25 cancellation fee. If you arrive more than 10 minutes late, we may not be able to treat you. This fee will be required to be paid before any additional treatments will be performed. We understand emergencies will happen. Therefore, a fee can be waived for an emergency and this fee can only be waived one time.

We appreciate you and your business and look forward to serving you!

Thank you,
Skin Renew Day Spa

Please sign below to acknowledge you have read and agree with this policy.

Client Name _____

Client Signature _____ Date _____

PRINT FORMS

v3.18