# Intake Form

## Section A

Name _____

Date _____

Address _____

_____

_____

Postal Code _____

Phone Number _____

Email _____

Date of Birth _____

Gender _____

## Section B - Lifestyle

Occupation _____

Stress Level _____

**Do you exercise?** Yes [ ] No [ ]

How often? _____

What type (of exercise)? _____

_____

Daily Water Intake _____

Diet _____

**Do you drink alcohol?** Yes [ ] No [ ]

How much (per week)? _____

_____

**Do you smoke?** Yes [ ] No [ ]

Average per day? _____

**Do you drink caffeine?** Yes [ ] No [ ]

Average per day? _____

## Section C

Are you **pregnant?** Yes [ ] No [ ]

Are you **lactating?** Yes [ ] No [ ]

Are you taking **contraceptives or any hormone supplements?** Yes [ ] No [ ]

## Section D - Health

***Please answer yes or no unless otherwise indicated***

**Are you:**

Under a physician's care for any medical condition? Yes [ ] No [ ]

Being treated for any other medical condition? Yes [ ] No [ ]

Currently using steroids or steroid cream products? Yes [ ] No [ ]

Taking any medications/natural remedies? List them: Yes [ ] No [ ]

_____

**Do you have:**

- Any allergies Yes [ ] No [ ]
  - AHA's or BHA's Yes [ ] No [ ]
  - Gluten/Nut Allergy Yes [ ] No [ ]
  - Antibiotics Yes [ ] No [ ]
  - Food Allergies _____ Yes [ ] No [ ]
  - Fragrance _____ Yes [ ] No [ ]

- Asthma Yes [ ] No [ ]
- Diabetes Yes [ ] No [ ]
- Epilepsy Yes [ ] No [ ]
- Psoriasis Yes [ ] No [ ]
- Kidney disease Yes [ ] No [ ]
- Shingles Yes [ ] No [ ]
- Thrombosis Yes [ ] No [ ]
- Burns/grafted skin Yes [ ] No [ ]
- Thyroid condition Yes [ ] No [ ]
- Keloid scar formation Yes [ ] No [ ]
- Hormonal imbalance Yes [ ] No [ ]
- A heart condition Yes [ ] No [ ]
- High blood pressure Yes [ ] No [ ]
- Cold Sores Yes [ ] No [ ]
  - Are they recurring? Yes [ ] No [ ]

## Section E - SkinQuest

***What is your current skincare routine?***

**Do you:**

- Cleanse Yes [ ] No [ ]
- Tone Yes [ ] No [ ]
- Exfoliate Yes [ ] No [ ]
- Use Masks Yes [ ] No [ ]
- Use Serums Yes [ ] No [ ]
- Use Eye Creams Yes [ ] No [ ]
- Moisturizer Yes [ ] No [ ]
  - Daily SPF Level _____

What are your concerns with your skin? _____

_____

What would you like to achieve today? _____

_____

Are your currently using Benzoyl Peroxide, Alpha Hydrox or Beta Hydroxy Acids? Yes [ ] No [ ]

Have you ever had injections, fillers, chemical peels or laser treatments? If so, when? _____ Yes [ ] No [ ]

Would you be okay with 3-7 days of downtime, which may include peeling? Yes [ ] No [ ]

Client Signature _____

Print Name _____ Date _____

Skincare Professional _____ Date _____

***I certify that all the above information is accurate, and if any changes occur I will notify this clinic immediately.***