Client Intake Form

I. General Information

Name: _____ Date: ____ / ____ / ____

Email: _____ ☐ I am willing to receive promotions and communications through email.

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Date of birth: ____ / ____ / ____ Employer: _____ Occupation: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

II. Medical History

Please check all that apply to you:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Fibromyalgia
- ☐ Heart attack/coronary artery disease
- ☐ Hepatitis A, B or C
- ☐ Herpes/cold sores (oral/genital)
- ☐ HIV/AIDS
- ☐ History of keloid/scarring
- ☐ Bleeding disorder
- ☐ Breast lump
- ☐ Cancer
- ☐ Connective tissue Disorder
- ☐ Chemical dependency
- ☐ Lung disorder/oxygen therapy
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Neuromuscular disorder
- ☐ Pacemaker or defibrillator
- ☐ Polycystic ovaries
- ☐ Chronic fatigue
- ☐ Clotting disorder
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Epilepsy
- ☐ Psychiatric disorder
- ☐ Pigmentation disorder
- ☐ Seizures
- ☐ Skin lesion
- ☐ Stroke

Please explain any of the above: _____

Any history not listed: _____

III. Allergies

Please list any medication allergies: _____

_____

Are you allergic to Latex?

- ☐ Yes
- ☐ No

Are you allergic to Iodine?

- ☐ Yes
- ☐ No

IV. Medications

Please list any medications or supplements (aspirin, herbal medicine, fish oil, vitamins, etc) you are taking:

_____

_____

_____

- ☐ Vitamin A (Retin-A, Renova, Differin)
- ☐ Hydroquinone
- ☐ Accutane (current or within past 6 months)
- ☐ Other skin care medications/topical agents (including OTC):_____ _____
- ☐ Blood thinner (Aspirin, NSAIDs, Coumadin, Xarelto, Pradaxa)
- ☐ Male hormone therapy (injections, gel)
- ☐ HCG injections
- ☐ HCH injections
- ☐ Weight loss (Adipex, Diethylpropion)
- ☐ Oral/implantable contraception

V. Nature of your visit

- ☐ Neuromodulators (Botox, Dysport, Xeomin)
- ☐ Dermal fillers (Juvederm, Restylane, Radiesse, Perlane)
- ☐ Skin care/treatments
- ☐ Weight loss
- ☐ Hormone therapy
- ☐ Laser hair removal
- ☐ Sclerotherapy (vein removal)

VI. Concerns/Interests

- ☐ Unwanted hair
  Area:_____
- ☐ Acne (active)
- ☐ Rosacea
- ☐ Dryness
- ☐ Fine lines
- ☐ Wrinkles
- ☐ Large pore size
- ☐ Discoloration
- ☐ Loss of skin tone
- ☐ Pigmentation
- ☐ Sun spots
- ☐ Broken capillaries/veins — varicose/spider
- ☐ Acne scars
- ☐ Oily skin

Other concerns? Please list: _____

_____

Are you wearing contact lenses?

- ☐ Yes
- ☐ No

Do you have metal implants?

- ☐ Yes
- ☐ No

VII. Skin Care

What is your daily skin care regimen? _____

_____

What make-up do you use? _____

How often do you work outdoors? ☐ Frequently ☐ Occasionally ☐ Rarely

Have you or any family member had skin cancer? ☐ Yes ☐ No

If yes, please explain: _____

Do you burn from sun exposure? ☐ Frequently ☐ Occasionally ☐ Rarely

How often do you use a sunscreen? ☐ Frequently ☐ Occasionally ☐ Rarely

How often do you use tanning beds? ☐ Frequently ☐ Occasionally ☐ Rarely

Which of the following best describes your skin type?

- ☐ Very oily skin, large pores
- ☐ Dry skin
- ☐ Oily skin
- ☐ Combination skin, oily in T-zone, dry to normal cheeks
- ☐ Sensitive skin
- ☐ Uncertain

AUTHORIZATION

Patient is responsible for all charges incurred. At this time, the office will **NOT** file insurance. Payment in full is due at time of service.

I, _____, have full read and understand the above statement of payment policy. I authorize the physician(s) to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician, physician assistant and nurse practitioner, and I consent to care by such providers. I understand these services are voluntary and that I have the right to refuse these services.

_____ _____

Signature Date

***Please allow 24 hours notice in the event of appointment cancellation.**

Patients with more than two (2) no-shows or late appointments **will be charged a service fee of $100** for future appointments.

I authorize this facility to release information to (please check all that apply and provide first/last name and phone numbers):

- ☐ Spouse: _____
- ☐ Children: _____
- ☐ Others: _____
- ☐ No one

_____ _____

Signature Date