intake form

cleanse STUDIO

All information given is private and confidential Date_____

Name _____ Date of Birth _____ Age _____

Phone _____ Email _____

Address _____

City _____ State _____ Zip _____

Do you have or have you had any of the following:

- ☐ Pacemaker
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Cancer (Ask for Oncology form)
- ☐ Stroke
- ☐ Plates/Implants/Pins
- ☐ Joint Replacements
- ☐ Thyroid Conditions
- ☐ Diabetes
- ☐ Herpes or Cold Sores
- ☐ Claustrophobia
- ☐ Eczema
- ☐ Psoriasis
- ☐ HIV/AIDS
- ☐ Skin Pigmentation
- ☐ Acne
- ☐ Keloid Scars
- ☐ Rosacea
- ☐ Other _____

Are you pregnant, possibly pregnant, or breast-feeding?

☐ Yes ☐ No

List all current medications _____

_____

List all allergies (food, environmental, medication, skincare products, etc.)

_____

_____

Are you using or have used any of the following?

- ☐ Retinoids
- ☐ Hydroquinone
- ☐ Steroids/Cortisone
- ☐ Benzoyl Peroxide
- ☐ Isotretinoin (Accutane)
- ☐ Alpha or Beta Hydroxy Acids (Glycolic, Lactic or Salicylic)

What skin care products do you currently use? (Cleanser, toner, exfoliator, serum, moisturizer, eye cream, etc.)

_____ _____

_____ _____

When did you last expose your body to the sun, sun lamp or tanning bed? _____

Please check areas of concern:

- ☐ Sun Damage
- ☐ Oil Control
- ☐ Pore Size, Surface Condition or Texture
- ☐ Pigmentation: Redness or Discoloration
- ☐ Acne and/or Blemish Control
- ☐ Dryness and/or Irritation

Have you recently had any of the following?

- ☐ Cosmetic Surgery
- ☐ Botox, Fillers or Injections
- ☐ Waxing
- ☐ Laser Resurfacing, CO_2, Photo Facials, Chemical Peels

It is my responsibility to notify the esthetician of any health conditions, allergies and medications. I understand my treatments will be based upon the information I have provided. I understand estheticians are not able to diagnose or treat any medical conditions and any health concerns I have should be addressed by a doctor or other qualified medical health practitioner.

I also understand and agree to assume the following risks and hazards which may occur in connection with any particular treatment including but not limited to: unsatisfactory results, soreness, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in skin pigmentation, allergic reaction, muscle damage or increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to unconditionally defend, hold harmless and release from any and all liability the company and the individual that provided my treatment, the insured, and any additional insureds, as well as any officers, directors or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment that I receive. I have fully disclosed any medications, previous complications or current conditions that may affect my treatment. My signature below constitutes acknowledgment that all the information I have provided is true and accurate.

Signature _____ Date _____

Parent or Guardian Signature _____ Date _____
(If client is under the age of 18)