Topeka Acne Skin Care

Anti-aging intake form

Name: _____
Address:_____ Apt#____ City/State_____ Zip _____

Telephone: (Primary)_____(Alternate) _____
E-mail Address:_____ Birthday: (mo/date)_____ Age:_____

How did you hear about us? _____

1. Have you had any of these health problems in the past or present? (please circle)

Cancer diabetes epilepsy heart problem hysterectomy systemic disease

Hormone imbalance spinal injury thyroid condition veins HIV/AIDS Hepatitis

Please indicate other:_____

2. Are you on any prescription medication? If yes, please list them here:_____

3. What skin care products are you currently using? Manufacture/product line_____

Circle – Cleanser toner exfoliation serum eye cream sunscreen moisturizer mask
Please indicate other:_____

4. Have you ever had peels, laser, microdermabrasion, dermaplaning or any resurfacing treatment? Yes No
If yes, which one & when was the last treatment:_____

5. Are you currently using any products that contain the following ingredients?
Circle – glycolic salicylic lactic mandelic enzyme vitamin A derivatives (i.e. retinol)

6. What are your skin care goals?

Circle - Acne Deep Cleansing Reduce Pigmentation Dehydrated Dry Sagging Fine lines Deep wrinkles Texture Scaring

Other_____

7. Have you ever had any negative reaction to skin care products? Yes No _____

8. Are you taking oral contraception? Yes No Are you pregnant or trying to become pregnant? Yes No

9. Are you under a lot of stress? Yes No 12. How much water are you drinking? _____

10. How would you rate your diet? very healthy/moderately healthy/ not healthy at all 14. Do you smoke? Yes No

Please read the following information: I understand that the therapeutic session I receive is provided for the basic purpose of relaxation and skin care. I understand that some redness/irritation is possible, after care will be provide. If I experience any pain or discomfort during this session, I will immediately inform the Esthetician. I affirm that the above information is accurate and true to the best of my knowledge, and to keep the practitioner updated as to any changes in my medical profile. I understand that there shall be no liability on the practitioner's part should I fail to do so. I do hereby waive, release and forever discharge Topeka Acne Skin Care from any and all responsibility or liability related to my service.

Print_____ Signature_____Date_____