justWELLNESS

104 Broadway 1st Floor, Hanover, PA 17331 717-634-5660

Confidential Intake Consent Form for Skin Care and Esthetics

Name:_____ Date:_____

Address: _____

City, State, ZIP: _____

Home Phone: _____ Work/Cell Phone: _____

Profession: _____

Email Address: _____ Birthdate: _____

Emergency Contact Name and Phone Number: _____

How did you hear about us? _____

I certify that the below information is correct to the best of my knowledge. In accordance with the law, Esthetics/Skin Care Therapy cannot cure, treat, prevent or diagnose any condition. These treatments are used as regimens for improving skin appearance and wellness. Information exchanged during any session should be given at my own discretion.

Because certain esthetics treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the skin care therapist updated as to any changes in my health prior to any future sessions and understand that there shall be no liability on the therapist's part nor on the part of Just Wellness should I fail to do so.

The therapist reserves the right to refuse service or to stop service to anyone for any reason.

I understand that if I am late to an appointment that the accumulated time will be deducted from my scheduled appointment or my appointment will be rescheduled.

I fully understand that the therapist performs his or her services within the parameters of esthetics, using skin care treatments and therapies. I fully understand that the esthetics therapist is not an allopathic doctor, dermatologist, or psychiatrist and does not portray himself/herself to be.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the products and/or techniques may be adjusted to my level of comfort.

By signing below, I acknowledge that I have read and understand all parts of this consent/intake form, and that I have had the opportunity to ask any questions with regard to any services or therapies offered.

All client information is confidential.

Client Name Printed: _____

Client Signature: _____

Date: _____

How would you rate the overall quality of your skin? POOR FAIR GOOD VERY GOOD EXCELLENT

What kind of skin do you think you have? _____

What is your current skin care regiment (cleansings, masks, scrubs, creams? _____

_____

Have you ever received professional skin care/esthetics treatments? Yes / No

If yes, what type? _____

Have you been under the care of any physician, dermatologist, or other medical professional within the past year? Yes / No

If yes, please explain: _____

_____

List any medications, supplements, or herbal/homeopathic remedies, topical medication or exfoliating acids like salicylic or glycolic? _____

_____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid, or any Vitamin A/Retinol derivative? Yes / No If yes, have you used these products within the last 3 months? Yes / No

Have you ever used an acne medication? If yes, when and which one? _____

Have you ever had an adverse reaction to a cosmetic product? Yes / No

If yes, please explain: _____

Are you bothered by scents, oils or lotions? Yes / No If yes, please explain: _____

Do you wear contact lenses? Yes / No Are you wearing them now? Yes / No

When you go out in the sun, do you? (circle one of the following)

ALWAYS BURN USUALLY BURN SOMETIMES BURN RARELY BURN NEVER BURN

Have you ever had an allergic reaction to food, sunscreens, or AHAs? Yes / No

If yes, please explain: _____

How many glasses of water do you drink per day? _____

On a scale of 1 to 10 (1=low / 10=high), how would you rate your current stress level? _____

Have you ever been treated for: (circle all that apply)

Acne Depression Skin Disease High Blood Pressure Frequent Cold Sores Diabetes Skin Cancer

Hormone Imbalance Hepatitis Herpes Skin Lesions Keloid Scaring Metal Bone Pins/Plates

If you wear a hormone or nicotine patch, please indicate which kind and where you wear it: _____

_____

I have stated all my known physical conditions and medications, and I will keep the skin care therapist updated on any changes.

Client Signature:_____ Date:_____