Confendential Skin Care
Intake Form

Inspiring Wellness

Please print clearly.

Name: ____Date_______________

Address: _____________________________City:__________________ Zip: _________

E-mail: ____

May we contact you via email about future promotions and news? □ Yes □ No

Birth date: _________________________ Phone: ________________________

Referred by; or how did you hear about us?::_____________________________________

Emergency contact: __________________________Phone: ______________________

Have you had a Facial before? □ yes □ no If yes, how long ago? ____________________

Your Health:

1. Within the last year, have you been under a dermatologist's or other physician's care?
□ yes □ no if yes, please explain::____

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2. Have you had any heath problems in the past or present? □ yes □ no if yes, please

specify____

3. Do you Smoke? □ yes □ no
4. How many glasses of Water do you drink a day ?___________
5. Exposure to the sun: □ Never □ Light □ Moderate □ Excessive
6. Do you have metal implants, a pacemaker or body piercings? □ yes □ no
7. List any allergies: ____
8. List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly.

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9. Rate your level of stress on a scale of 1 to 4 (1=low stress, 4=high stress) _____________

*Women Only: Are you Pregnant? □Yes □No If yes, how far along? ____________________

Your Skin:

10. Have you ever had Chemical Peels, Microdermabrasion or any resurfacing treatments?
    □Yes □No

11. Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? □ yes □ no In the last 3 months? □ yes □ no

12. Are you currently using any products that contain the following ingredients?
    □ glycolic acid □ lactic acid □ any exfoliating scrubs □ any hydroxy acid product
    □ vitamin A derivatives (i.e. retinol)

13. What skin products are you currently using? □Soap □Cleanser □Toner □Moisturizer □Serum
    □Mask □Exfoliate □Eye product.

14. What are your treatment goals?

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I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I am aware that there are often inherent risks associated with skin care services and that the services I am about to receive could have unfavorable results including but not limited to allergic reaction, irritation, burning, redness, scarring, soreness, etc. By signing below, I further agree that I will not hold Amb Day Spa, or its affiliates, or any of its employees responsible should there be any unfavorable outcome or result.

____ ______________________

Client signature Date

____ ______________________

If under 18 Parent’s signature Date

Thank you for visiting Amb Day Spa!

For Next Appointment:
(Do not sign if this is your first appointment.).

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Signature: ______________________________ Date: ______________
Signature: ______________________________ Date: ______________
Signature: ______________________________ Date: ______________
Signature: ______________________________ Date: ______________
Signature: ______________________________ Date: ______________
Signature: ______________________________ Date: ______________

Treatment Record(to be completed by staff):

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