



Angelface Spa Client Intake Questionnaire

Date: _____

Personal information

Name (please print): _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Email: _____

How did you learn about Angelface Spa? _____

Optional information

Single Married Anniversary: _____

Spouse's Name/Occupation: _____

Your Occupation: _____

Are you interested in receiving information on special offers or discounts? Yes No

Medical information

What is the name of your general physician? _____

Address? _____

Phone number? _____

Medications (internal & topical: Please check all that apply and write the name of the medication next to box.)

Hormone replacements: _____ Antibiotics: _____

Steroids: _____ Any acne medication: _____

Retin A (or any product with Retin A in it) : _____ Accutane

Are you presently taking any other medications (internal or topical)? Yes No

If yes, please list. _____

Have you recently stopped taking any medications? Yes No

If yes, please list. _____

Have you taken any of the medications listed above in the last 3 months? Yes No

If yes, please list what & for how long: _____

Please list any vitamins or supplements taken regularly. _____

Do you have any allergies? Yes No

If yes, please list. _____

Have you had any recent surgeries? Yes No

If yes, please explain. _____ When? _____

Do you have a pacemaker? Yes No Do you have any metal implants? Yes No

Check all that apply:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Condition | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Telangiectasia | <input type="checkbox"/> Prone to cold sores | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Large moles or warts | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Low Pain Threshold | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Contact Lenses | |

Personal skin evaluation and additional information

Are you presently under the care of a Dermatologist? Yes No

What is the name of your Dermatologist? _____

Address? _____

Phone number? _____

Reason for Dermatologist visit? _____

Would you consider your skin to be: Oily Dry Combination Normal

Please check areas of concern:

- Wrinkles/fine lines
- Acne/Blemish control
- Acne scarring
- Large pores
- Sensitive
- Rosecea
- Broken capillaries
- Oily
- Dry
- Dehydrated
- Stress reduction & relaxation benefits

Do you have any hyper-pigmentation? Yes No
(sun spots, age spots, liver spots, brown spots, masking)

If cause is known, please check:

- Pregnancy
- Birth Control Pills
- Antibiotics
- Sun damage
- Illness

How long have you had these? _____

Are you presently using any skin lighteners, bleaching creams/serums, hydroquinone?

Yes No

Name of product: _____

How long have you been using and how often do you apply? _____

Have you used any topical lightening products in the past that you are not presently using?

Yes No

Name of product: _____

How long ago did you use and how often did you apply? _____

Do you sunbathe or go tanning? Yes No

When was the last time? _____ How often do you do this? _____

Do you participate in outdoor activities? Yes No

Please explain: _____

Do you wear sunscreen regularly? Yes No What SPF? _____

Do you usually burn or tan when exposed? Burn Tan

Have you used any self-tanning lotions, creams or treatments with in the last two weeks?

Yes No

Name of product: _____ How long ago? _____

Personal skin evaluation and additional information (cont.)

What is your daily water consumption? _____

Caffeine consumption? _____

How often do you drink alcohol? _____

Smoke tobacco? _____

Do you exercise regularly? Yes No What do you do? _____

Have you ever had any of the following (if yes, please write how long ago)?

- | | |
|--|--|
| <input type="checkbox"/> Cosmetic Surgery (_____) | <input type="checkbox"/> Botox Injections (_____) |
| <input type="checkbox"/> Restylane (_____) | <input type="checkbox"/> Collagen (_____) |
| <input type="checkbox"/> Skin Cancer (_____) | <input type="checkbox"/> Dermatitis (_____) |
| <input type="checkbox"/> Keloid Scarring (_____) | <input type="checkbox"/> Laser Resurfacing (_____) |
| <input type="checkbox"/> Chemical Peels (_____) | <input type="checkbox"/> Facial (_____) |
| <input type="checkbox"/> Filler injections of any kind (_____) | |

Have you ever had an allergic reaction to any skin care product or a cosmetic? Yes No

Please explain: _____

Would you consider your skin to be sensitive? Yes No

Do you blush easily? Yes No

Do you redden easily/react quickly to touch and topical products? Yes No

Would you consider your stress level to be Low Medium High

How much sleep do you average per night? _____

♀ FEMALE CLIENTS ONLY:

Are you pregnant or trying to become pregnant? Yes No

Are you taking oral contraceptive? Yes No Specify: _____

Have there been any changes to your contraceptive treatment within the last 3 months?
 Yes No

Are you lactating? Yes No

♂ MALE CLIENTS ONLY

What is your current shaving system: Wet shave Electric

Do you experience irritation from shaving? Yes No Ingrown hairs? Yes No

PRESENT HOME CARE REGIMINE

Please tell me what products you use at home

Cleanser: _____

Toner: _____

SPF: _____

Moisturizer: _____

Exfoliator: _____ How Often? _____

Mask: _____ How Often? _____

Eye treatment: _____

What are you hoping to achieve during this visit? _____

Additional remarks: _____

Future appointments/communication:

May I call you at home, work, or cell phone to confirm future appointments? Yes No
Do you have a problem with me leaving messages with any persons other then you in regards to our appointments? Yes No May I contact you via mail or email? Yes No

Consent:

I understand, have read and completed this questionnaire truthfully. I understand that withholding any information or providing any misinformation in the present now or in the future may result in contraindications and/or irritation to the skin from treatments received. I agree to follow all post treatment protocols recommended by Angelface Spa / Melinda Whedon. I agree to keep Angelface Spa / Melinda Whedon informed if any of my answers in this questionnaire change. The treatments I receive here are voluntary, and I release Angelface Spa / Melinda Whedon from liability and assume full responsibility thereof.

Name (printed) _____

Signature _____ **Date** _____