Client Intake Form

509 Highbury Ave N
London, ON N5W 4K6
Between Florence and Brydges
(Inside Mobility Massage)

Date:_____

Name:_____**Date of Birth:**_____ **Age:** _____
Address:_____**Gender:** ☐ **Male** ☐ **Female**
City, Postal Code_____**Home #(** _____**)**_____
Email: _____ **Cell# (**_____**)** _____

Allergies:

_____

Current medications (topical & oral)

_____

Have you ever experienced any of the following conditions?

☐ Metal Implants/Pins
☐ Pacemaker/Defibrillate
☐ Diabetes
☐ Hormone Imbalance
☐ Epilepsy/Seizures
☐ Blush/Redden Easily
☐ Psoriasis
☐ Rosacea
☐ Eczema
☐ Bruise Easily
☐ Skin Disease/Disorder
☐ Fungal infection
☐ Eye sensitivity or allergy
☐ Spf allergy (sunscreen)
☐ Other: _____

Do you wear contacts?
☐ **Yes** ☐ **No**

Are you currently under the care of a physician or dermatologist? ☐ **Yes** ☐ **No**
If so, explain.

_____

Any surgeries within the last 6 months? ☐ **Yes** ☐ **No** **If so, explain.**

_____

Any dermal injections/fillers with in the last 6 months? ☐ **Yes** ☐ **No**
If so, explain.

_____

Are you using any products that contain…?

Retin –A, Renova, Adapalene Hydroxyl Acid, Differin, Glycolic Acid, AHA/BHA, Salicylic Acid, Lactic Acid, Retinol/Vitamin A, Accutane or any other prescription or over the counter skin product?

☐ **Yes** ☐ **No**

Have you used any of these products in the past 3 months?
☐ Yes ☐ No If so, explain.

_____

Have you ever had any of the following treatments?

☐ Facial	☐ Waxing Sugaring	☐ Laser Resurfacing
☐ Body Scrub	☐ Microdermabrasion	☐ Botox Injections
☐ Body Wrap	☐ Chemical Peel	☐ Juvaderm fillers

Have you ever had any allergic reaction to any skin products?
☐ Yes ☐ No If so, explain:

_____

Do you wear sunscreen daily? ☐ Yes ☐ No

What temperature water do you cleanse your skin with?
☐ Cold ☐ Warm ☐ Hot

What is your skin type?

☐ Oily ☐ Dry ☐ Normal ☐ Combination ☐ Sensitive ☐ Super dry

Would you like to be notified of any promotion?

☐ Yes, How? ☐ Email ☐ Phone ☐ Text ☐ No

How did you hear about us?

☐ Facebook ☐ Mobility Massage ☐ Vehicles ☐ Poster ☐ Kijiji ad

☐ Instagram ☐ Google ☐ Referral ☐ Other

Who can we thank for referring you? _____

Do you have any preferred days or times for your appointment?

☐ Mo ☐ Tu ☐ We ☐ Th ☐ Fri ☐ Sa ☐ Su **Time(s)** _____

Client Consent:

I understand, have read and completed the questionnaire truthfully. I agree that this constitutes full disclosure, and that it supercedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the esthetician in giving better service and is completely confidential. The treatments I receive here are voluntary and I release Grace beauty Spa and/or skin care professional from any liability and assume full responsibility thereof.

Client Signature _____ **Date:** _____
Esthetician Signature _____ **Date:** _____