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CONFIDENTIAL CLIENT INTAKE
SKIN CARE/AESTHETICS

Name: _____ Date: _____

Address: _____

Phone: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Occupation: _____

EMERGENCY CONTACT: _____

Name: _____

Relationship: _____ Phone: _____

GENERAL HEALTH INFORMATION: _____

1. How did you hear about us? Advertisement Family/Friend Website Internet Search

Other source _____

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

If yes, what type: _____

3. Have you been under the care of any physician, dermatologist, or other medical professional within the past year?

If so, please explain: _____

4. List any medications, supplements, or herbal/homeopathic remedies you currently take: _____

5. Are you using any topical medication or exfoliating acids like salicylic or glycolic? Yes No

If yes, explain: _____

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

If yes, explain: _____

7. What are you currently using to cleanse and moisturize your face? _____

Are you happy with the results? Yes No

8. Do you currently use any special treatments? (eye , scrubs, masks, etc.) _____

9. How would you rate the overall quality of your skin? Poor Fair Good Very Good Excellent _____

10. What improvements would you like to see to your skin? _____

11. When you got out in the sun, do you: Always burn Usually burn Sometimes burn Rarely burn Never burn _____

12. How many glasses/cups of water do you drink daily? _____

13. On a scale of 1-10, how would you rate your current stress level? (low) 1 2 3 4 5 6 7 8 9 10 (high) _____

14. Have you ever been treated for: (Check all that apply) _____

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

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

15. Do you wear contact lenses? Yes No and are you wearing them now? Yes No _____

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

17. Are you bothered by scents, oils or lotions? Yes No If yes, explain _____

18. 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 _____

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

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

 If yes, please explain: _____

SKIN CARE CONSENT FORM

I certify that the above 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 Healing Roots Massage, should I fail to do so. The therapist reserves the right to refuse service to anyone for any reason.

I fully understand that the therapist performs 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 _____