

# Naturally Connected Esthetics

## Facial Information form

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Mobile \_\_\_\_\_

Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone: \_\_\_\_\_

### *Skin Care Analysis*

Have you had a skin treatment before? Y/N

Have you seen a dermatologist in the last 5 years? Y/N if Y explain. \_\_\_\_\_

Are you pregnant? Y/N # of weeks \_\_\_\_\_

Do you have any allergies to skincare products? \_\_\_\_\_

Are you using any topical medications? \_\_\_\_\_

Have you had cosmetic / plastic surgery? \_\_\_\_\_

Do you have Rosacea? Y/N \_\_\_\_\_

Have you ever or are you currently using Retin-A, Acutane or any AHA's \_\_\_\_\_

Do you have any implants, (pacemaker, pins in bones etc..) \_\_\_\_\_

Do you wear contact lenses? Y / N

How do you rate your stress level? \_\_\_\_\_

What are some of your skin concerns? \_\_\_\_\_

When do you notice oil on your skin? Morning \_\_\_\_\_, Afternoon \_\_\_\_\_ or evening \_\_\_\_\_

What products are you currently using?

Cleanser \_\_\_\_\_

Exfoliator \_\_\_\_\_

Day cream \_\_\_\_\_

Night Cream \_\_\_\_\_

Body Care \_\_\_\_\_

Mask \_\_\_\_\_

- I have completed the Facial Intake form accurately. I have been candid in revealing any conditions that could prohibit treatment(s), such as cold sores, pregnancy, use of hormones, recent facial surgery or laser resurfacing, recent use of Retin A or use of Accutane within the last 18 months.
- I acknowledge that the possibility of an adverse reaction to a Facial, can occur and that this is the case regardless of precautions taken. I accept sole responsibility for the treatments I receive and for any medical care that may become necessary. I will immediately contact the Esthetician who performed the treatment of any adverse reactions. In the event that I cannot reach such person, I will immediately seek medical care.
- The Esthetician has provided me the information necessary for me to have made the informed decision to proceed with the treatment(s). He/she has answered all of my questions concerning the treatment(s). I clearly understand the above information.
- I fully understand that Naturally Connected and its agents may refuse to perform the treatment(s) I have requested if I have answered “yes” to any of the intake questions. I understand that I have given up substantial rights by signing this release and that it represents an agreement between Naturally Connected and me. I agree that my participation in treatment(s) is voluntary and I accept the inherent risks.
- I hereby release Naturally Connected, its agents, owners, employees, successors and assigns, and suppliers from any and all damage or injury that may result from the treatment I receive. I represent that all the information provided by me has been true and correct. I am over the age of 18 years old. I hereby authorize the therapist to perform said treatment(s).

We are a **Health Insurance Portability and Accountability Act (HIPAA)** compliant facility.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_