Patient/Client Intake Form

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Last Name:_____ Name: _____ Gender: M __ F __Date Of Birth:_____
(mm/dd/yyyy)

For office use only
DRIVER'S LICENSE NUMBER: _____ PHOTO ID: Y ___ N___

Address: _____ Apt: _____ City: _____
Postal Code: _____ Home Phone: _____Bus: _____
Cell: _____ Email: _____ Occupation: _____
Who May We Thank For Referring You To Our Care? _____
Name of family member, friend, co-worker, internet, yellow pages, street sign etc.

General Health – Check All That Apply

- ☐ Heart Problems Diabetes ☐ High/Low Blood Pressure
- ☐ Over/Under Active Thyroid ☐ Hormonal Problems ☐ Skin Cancer
- ☐ Allergies (Please List): _____

Are You Currently Under The Care Of A Physician/Dermatologist? ☐Yes ☐ No
List Any Medications You May Be Using (Topical And Internal)_____

Please Indicate The Following

Do You Have Any Implants Or Pacemakers?	☐ Yes ☐ No
Do You Wear Contact Lenses?	☐ Yes ☐ No
Do You Smoke?	☐ Yes ☐ No
Do You Have Sinus Problems?	☐ Yes ☐ No
Are You Currently Pregnant?	☐ Yes ☐ No
Are You Pre Or Post Menstrual (3 Days)?	☐ Yes ☐ No
Do You Have A Tendency Towards Redness, Rashes Or Hives?	☐ Yes ☐ No
Recent Injury or Surgery?	☐ Yes ☐ No

Skin History – Have You Recently Had?

- ☐ Laser Surgery ☐ Microdermabrasion ☐ Sunburn/ Excess Sun Exposure
- ☐ Rash/Hives ☐ Chemical Peel ☐ Waxing/ Hair Removal

Are You Currently Using Any Of The Following?

- ☐ Retin-A/Renova© ☐ Accutane© ☐ Alpha/Beta Hydroxy Acid Products
- ☐ Topical Acne Cream ☐ Bleaching Creams ☐ Other: _____

Regarding Skin Care What Are Your Immediate Concerns?_____
_____
What Are You Currently Using As A Home Care Regimen And How Often?_____
_____

Have You Experienced An Adverse Reaction To Any Skin Products? ☐ ☐ Yes No
If Yes, Explain:_____

Informed Consent and Release

I _____ do fully understand all the questions above and have answered them correctly and honestly. I understand that the services offered are not a substitute for medical care and that either esthetician InsideOut Wellness Centre or their staffs are providing medical advice, instruction or treatment. I understand that the esthetician has informed me of what to expect in the course of treatment, and will recommend adjustments to my regimen if deemed necessary. I understand that with any facial treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks and expressly agree to release my attending esthetician and InsideOut Wellness Centre and its staff of any claim and/or potential liability from any result that may occur from my use of these services or the use of any products.

I understand that InsideOut Wellness Centre can provide courtesy notification for my appointments via text, e-mail or telephone. It is my responsibility to note the time and date of all my appointments. I understand that a minimum of 24 hours notice is required to change or cancel my appointment.

Signature:_____ Date:_____

Print Name:_____ Esthetician: _____

Most Services Are Covered By Extended Health Insurance. Please Check With Your Benefits Administrator At Work.

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