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.

Full Name		
Date of Birth (MM/DD/YYYY):		Gender: Male or Female
Cell Phone:	Home Phone:	Work Phone:
Email Address:		
Address:		
City:	Province:	Postal Code:
Occupation:		
Who may we thank for referring you to our care?		

General Health History: Please check any or all of the following which apply to you:			
Anxiety		Chemo/Radiation	
Diabetes		Tuberculosis	
Infection		Acne/Skin Conditions	
HIV/AIDS		Cold Sores	
Cancer/Tumours		Psoriasis/Rosacea	
Muscle/Joint Pain		Recent Surgery	
Asthma or Lung Problems		Hormone Imbalance	
Skin Sensitivities/Bruise Easily		Irregular Menstruation	
Bleeding		Recent Botox	
Pace Maker/ Metal Implants		Heart Disease	
High/Low Blood Pressure		Hepatitis	
Epilepsy		Bacterial Infection/STD	
Pregnancy (or trying)		Immune Disorders	
Skin History: Please check off if you have recently had any of the following:			
Laser Surgery		Rash/Hives	
Microdermabrasion		Sunburn/Excess Sun Exposure	
Chemical Peel		Waxing	
Are you currently using any of the following products?			
Retin-A/Renova		Accutane	
Topical Acne Cream		Bleaching Cream	
Alpha/Beta Hydroky Acid Products		OTHER:	
What are your immediate concerns about your skin?			

General Consent: I understand, have read and completed this questionnaire truthfully to the best of my ability. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I consent to the service being undertaken and I hereby indemnify InsideOut Wellness Centre and its Owners & Staff from any claims whatsoever. I understand this service is a cosmetic treatment and that no medical claims are expressed or implied. I understand that there are no guarantees or refunds as to the results of this service. I hereby agree to all of the above and grant my permission to have this treatment performed on me. All information is solely collected for the internal use of InsideOut Wellness Centre and will not be shared with any third parties. InsideOut Wellness Centre is the guardian of my file. My file will only be released with a duly executed authorization form signed by me.

Eyebrow and Eyelash Tinting may cause eye irritation and/or blindness. By signing this waiver, you consent that you understand the risks involved in this treatment and herby indemnify InsideOut Wellness Centre and its Owners & Staff from any claims whatsoever.

Client Name (Printed): ____

Client Signature: ____ Date: _______________