All Is Well
MASSAGE & SPA
Healing Hands To Pamper You

CLIENT INTAKE FORM – FACIAL

Name:_____D.O.B:_____

Address:_____City:_____State:_____Zip:_____

Phone:(H)_____(C)_____(W)_____

Referred by:_____Phone:_____

Occupation:_____Age:_____Male:_____Female:_____

Physician:_____Health Insurance Provider:_____

Is this your first facial? Yes _____No _____ Are you pregnant? Yes _____ No_____

Are you taking birth control pills? Yes _____No _____ Do you wear contact lenses? Yes _____No _____

Do you smoke? Yes _____No _____ Do you often experience stress? Yes _____No _____

Have you ever had skin cancer? Yes _____No _____ If yes describe:_____

Are you presently under a physician's care for any current skin condition or other problem? Yes _____No_____

If yes what? _____

Are you presently taking any medications? Yes _____ No _____

If yes list: _____

Are you now using or have you ever used Accutane? Yes _____ No _____

Do you have any allergies to cosmetics, food or drugs? Yes _____ No _____

What is your main concern with your skin? _____

What skin care products do you use presently? _____

_____

Are you presently using (or used in the past) Azlex, Differin, Renova, Retin-A, Tazarac, Glycolic or Alpha Hydroxy Acids? Yes _____ No_____

Please check if you are affected by or have any of the following:

- O Epilepsy
- O Fever blisters
- O Headaches
- O Chronic Anxiety
- O Hysterectomy Skin Disease Hepatitis
- O Eczema
- O Metal bone, pins, or plates
- O Asthma
- O High Blood Pressure
- O Sinus Problems
- O Immune Disorders
- O Lupus
- O Pace Maker

Please explain above problems or list any other significant issues: _____

_____

I understand that the services offered are not a substitute for medical care; and any information provided by the therapist, is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.
Cancellations:
We request a minimum of 24 hours notice for cancellations of any scheduled appointments or a minimum of 48 hours for a group cancellation to avoid any unnecessary changes. 50°/o of your scheduled services will be required without a 24 hour notice, and full price of your scheduled appointment will be required if no notice has been given. Late arrivals may result in reduced or cancelled service.

Client Signature:_____Date:_____

Provider Signature:_____Date:_____

Consent to Treatment of a minor: By the signature below, you hereby authorize All Is Well massage & Spa to administer a massage, bodywork or somatic therapy techniques to my child or dependent, as they deem necessary.

Signature of Parent or Guardian:_____Date:_____

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Client Skin Analysis/Evaluation (For Esthetician Use)

Name:_____ Date of Consult: _____

Address: _____ Age: _____ Gender:_____

City:_____ State: _____ Zip: _____

Known Allergies: _____

Medications:_____

Skin Classification

Fitzpatrick Classification: Type I Type II Type III Type IV Type V Type VI

Normal_____ Scars (acne, etc) _____

Dry_____ Photoaging_____

Dehydrated_____ Wrinkles_____

Mature_____ Superficial lines _____

Thin, sensitive skin _____ Deep lines_____

Oily_____ Relaxed elasticity_____

Open pores _____ Good elasticity_____

Comedones (blackheads)_____ Couperose (broken capillaries) _____

Milium (whiteheads)_____ Dilated capillaries_____

Asphyxiated (blocked pores and follicles) _____ Discolorations_____

Blemishes/Acne_____ Other: _____

How many years? _____ _____

Vulgaris: ___ No ____Yes Chronic: ____No ___Yes _____

Cystic: ____No ____Yes Rosacea: ____No ____Yes _____

Date:_____ Skin Care Professional:_____

Specific Concerns: _____

Type of treatment:_____

Notes/Remarks:_____

Recommended Home Skin Care Products:

For Day time:

_____

_____

_____

_____

For Night time:

_____

_____

_____

_____