All Is Well
MASSAGE & SPA
Healing Hands to Pamper You

FACIAL INTAKE FORM – NEW CLIENT

Esthetician Name: ______________________ **Service Booked**: ________________________________

Appointment Time: __________ AM / PM Date: **M** _______D__________ 202_____

Client Full Name: ____ **Date of Birth**: M_______D______Y___________

Are you taking birth control pills? Yes________No_____ Are you pregnant? Yes__________No___________

Do you wear contact lenses? 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, describe: ____

Are you presently taking any medications? Yes_______No_____

If Yes, list: ____

Are you now using it, 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
- O Skin Disease
- O Hepatitis
- O Eczema
- O Metal bone, pins, or plates
- O Asthma
- O High Blood Pressure
- O Sinus Problems
- O Immune Disorders
- O Lupus
- O Pacemaker

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

____

Add On: all add on services/treatments are incorporated within the primary skincare treatment time and will provide a booster to the relaxation, rejuvenation, and overall skin care treatment result

- ☐ Aloe vera Ice cube Face Massage $15 _______
- ☐ Cool Fresh Cucumber Mask $10 _______
- ☐ Peppermint/Lavender Scalp Massage $10 _______
- ☐ Sugar Scrub Hand Treatment $15 _______
- ☐ Mini Facial Gua Sha $15 _______
- ☐ Jelly Mask $15 _______
- ☐ Aromatherapy $10 _______
- ☐ Cold Stone Face Massage $15 _______
- ☐ Herbal Foot Spa $15 _______
- ☐ **Yam & Pumpkin Enzyme Peel $20** ________
- ☐ **Diamond Dermabrasion $30** ________
- ☐ **High Frequency $25** ________
- ☐ **Hungarian Enzyme Mask $20** ________
- ☐ **LED Light Therapy $30** ________
- ☐ **Dermaplaning $50** ________
- ☐ **Sothys Serum (Ampoules) $25** ________
- ☐ **Sothys Glysalac Peel $70** ________
- ☐ **Milk-Lemon-Salt-Rose Foot Spa $15** ________ **(Coming Soon)**

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.

Client Signature :_______________________________________ Date : **M** _______D_________ 202______

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.

Parent or Guardian Signature:_________________________________ Date: **M** _______D_________ 202______

Client Skin Analysis/Evaluation (For Esthetician Use Only)

Client Name:_________________________ Age: __________ Gender: __________

Known Allergies:____

Medications:____

Skin Classification

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

(circle all that apply)

Normal	Open Pores	Scars (acne, etc.)	Good elasticity
Dry	Comedones (blackheads)	Photoaging	Couperose (broken) capillaries
Dehydrated	Milium (whiteheads)	Wrinkles	Dilated capillaries
Mature	Asphyxiated (blocked pores and follicles)	Superficial Lines	Discolorations
Thin, sensitive skin	Blemishes/Acne	Deep lines	Other: __________
Oily		Relaxed elasticity	

How many years? ____________________________

Vulgaris ____No ___Yes Chronic: ____No ___Yes Cystic: ____No ___Yes Rosacea: ____No ___Yes

Date of Consultation (if applicable) ________________ **Date of Service (if applicable)** ________________

Specific Concerns:____

Type of treatment: ____

Notes/Remarks: ____

Recommended Home Skin Care Products:

For Day Time

____

____

____

For Nighttime

____

____

____

Skincare Professional Name ________________**Signature**_________________________ **M** _______D_________ 202______