



CLIENT INTAKE FORM

All information is kept strictly confidential.

CLIENT INFORMATION

Full name:	Date:	Date of birth:	
Address:		City:	State: ZIP:
Cell phone:	Email:		
Occupation:	Preferred contact:		
Emergency contact:	Relationship:	Phone:	

How did you hear about us?

- | | | |
|---|--|---|
| ☐ Instagram / social media | ☐ Friend or family referral | ☐ Physician referral |
| ☐ Google search | ☐ Returning client | ☐ Other: _____ |

YOUR SKIN GOALS

Services you are interested in:

- | | | |
|--|--|---|
| ☐ Laser therapy | ☐ Microneedling | ☐ Permanent makeup – brows |
| ☐ Permanent makeup – eyeliner | ☐ Permanent makeup – lips | ☐ Skincare consultation / products |

Primary concerns:

- | | | |
|--|--|--|
| ☐ Fine lines & wrinkles | ☐ Sun damage / dark spots | ☐ Uneven tone or texture |
| ☐ Acne or acne scarring | ☐ Enlarged pores | ☐ Loss of firmness |
| ☐ Redness | ☐ Melasma | ☐ Thinning brows / lashes |

Anything else you'd like us to know about your goals:

SKIN HISTORY & CURRENT ROUTINE

Current skincare products (cleanser, serums, SPF, etc.):

Previous aesthetic treatments & dates:

How does your skin respond to the sun? ☐ Always burns ☐ Burns, then tans ☐ Rarely burns ☐ Never burns

Skin type: ☐ Dry ☐ Oily ☐ Combination ☐ Normal ☐ Sensitive

HEALTH HISTORY

Certain conditions and medications affect which treatments are safe for you. Please answer every question.

Do you currently have, or have you had...	Yes	No
Pregnant, trying to conceive, or breastfeeding	☐	☐
Accutane / within the past 12 months	☐	☐
Retinol, Retin-A, tretinoin, or exfoliating acids in the past week	☐	☐
Blood thinners (aspirin, warfarin, etc.) or a bleeding/clotting disorder	☐	☐
Cold sores / fever blisters (herpes simplex)	☐	☐
Keloid or raised scarring, or poor wound healing	☐	☐
Diabetes	☐	☐
Autoimmune condition (lupus, rheumatoid arthritis, etc.)	☐	☐
Active acne, eczema, psoriasis, rosacea, or skin infection in treatment area	☐	☐
History of skin cancer or suspicious moles	☐	☐
Pacemaker, metal implants, or electronic devices	☐	☐
Seizure disorder or epilepsy	☐	☐
Sun exposure, tanning, or self-tanner in the past 2 weeks	☐	☐
Botox, fillers, or other injectables in the past 2 weeks	☐	☐
Chemical peel, laser, or microneedling in the past 4 weeks	☐	☐
Photosensitizing medications (certain antibiotics, etc.)	☐	☐

Current medications & supplements:

Allergies (medications, latex, lidocaine, pigments, etc.):

If you answered "Yes" to any item above, please explain:

ACKNOWLEDGMENT & CONSENT

I confirm that the information I have provided is complete and accurate to the best of my knowledge. I understand that withholding information may affect my results and safety, and I agree to inform SkinCare by Marcella of any changes to my health, medications, or pregnancy status before future treatments. I understand that results vary and are not guaranteed.

Photo consent: ☐ I consent to before & after photos for my client record
☐ I consent to anonymous use of my photos on social media / marketing

Client signature: Date:

Printed name: Provider initials: