



GLOW, LLC Client Intake Form – Aesthetics

Personal Information:

Name: _____ Date: _____

E-Mail: _____ Date of Birth: _____

How did you hear about us?

Address:

City: _____ State: _____ Zip Code: _____

Home Phone: _____

Cell Phone: _____

Occupation:

Emergency contact _____ Phone _____

1. Do you have any health problems or concerns that we need to be aware of before treatment?

If the answer is yes, please describe:

2. Are you pregnant? ___ Yes ___ No

3. Do you have any allergies? _____

4. Any recent surgery on your face, neck, and shoulders? ___ Yes ___ No

5. Are you currently, or have you taken Accutane with the past 12 months?
___ Yes ___ No

6. Are you currently, or have you used Retin-A/Renova, or any powerful alpha hydroxy acids within the past 3 months? ___ Yes ___ No

7. Have you had a chemical peel within the past 6 months? ___ Yes ___ No

8. Do you have a pacemaker or any pins in bones? ___ Yes ___ No

9. Do you currently wear contact lenses? Yes ___ No ___

10. Are you currently under a physician's care for any skin condition? If yes, please describe.

11. Have you ever had an adverse reaction to a cosmetic product or ingredient? If yes, please describe.

12. Have you ever had an adverse reaction to a skin care treatment? If yes, please explain.

13. What are your skin concerns and challenges?

14. What products are you currently using on your skin?

Daytime _____

Evening _____

Weekly / Special Treatments _____

Is there anything else about your health history that you think would be useful for your Esthetician to know to plan a safe and effective session for you?

Informed written consent must be provided by a parent or legal guardian for any client under the age of 18.

I, _____, [print name] understand that the session I receive is provided for the basic purpose of _____. If I experience any pain or discomfort during this session, I will immediately inform the esthetician so that the session may be adjusted to my level of comfort. I further understand that esthetics should not be construed as a substitute for medical examination, diagnosis, or treatment, and that I should see a physician, or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that licensed estheticians are not qualified to diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because esthetics should not be performed under certain medical conditions, I affirm that I have

stated all my known medical conditions, and answered all questions honestly. I agree to keep GLOW, LLC or the esthetician updated as to any changes in my medical profile and understand that there shall be no liability on GLOW, LLC and the esthetician's part should I fail to do so.

GLOW Cancellation Policy: 24 hour notice is required for any appointment cancellations or changes. With the exception of unexpected illness or emergency, full payment is expected for missed appointments with less than 24 hours notice.

Payment Policy: Full payment is required at time of service

Signature of Client _____ Date _____

Signature of Licensed Esthetician _____ Date _____