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AESTHETICS
Confidence Prescribed.

Intake Form

Last Name: ______________________________ First Name: _____________________________ Date: _________________

____
Address, City, State, Zip

Phone Numbers- Home: ______________________ Work: ______________________ Cell: _________________________
Cell Phone Carrier: _________________________ Do we have permission to send appointment reminders via text? Y / N

D.O.B.: ______________ Age_________ Email: ____
***Do you give us permission to contact you via email? (i.e. confirmations, follow ups and promotions?) Y / N**
****Do you give us permission to send mail to your residence? Y / N**

Emergency Contact Name & Number: ____

Where did you find out about us:
Google ☐ Instagram ☐ Facebook ☐ Advertisement ☐ Other ☐ Friend/Family ☐ (Name?:_______________________)

Occupation: ___________________________________ Ethnicity/race: ____

List ALL medications, supplements, or herbal/homeopathic remedies you currently take: ____________________________
____
____

List ALL Allergies: ____

Have you ever had an adverse reaction to a cosmetic product? Y / N If yes, please explain:________________________
____

Please indicate if you've had or used the following:

☐ Laser Treatments	☐ Depilatories	☐ Chemical Peels	☐ Differin/Adapalene gel
☐ Tanning Beds	☐ Electrolysis	☐ Microdermabrasion	☐ AHA/Glycolic Acid
☐ Waxing/Tweezing	☐ Cosmetic Surgery	☐ Retin-A/Tretinoin/Renova	☐ BHA/Salicylic Acid
☐ Facial	☐ Botox/Filler	☐ Accutane: When:____________	

If you've used any of the above have you used them within the last 3 months? Y / N

Lifestyle: Please Circle

Smoking	Y	N	Amnt (per week): _____	Caffeine	Y	N	Amnt (per day):	_____
Alcohol	Y	N	Amnt (per month: _____	Exercise	Y	N	Amnt (per week):	_____

Do you wear (Please Circle Y or N): Contacts/Glasses: Y / N Hearing Aid: Y / N Dentures: Y / N

Surgery: Please list any previous surgeries and their dates (including cosmetic surgery):

____

____

Medical History: Please Circle Y or N whether you have or have ever had the following:

Abnormal Bleeding	Y	N	Asthma/Difficulty Breathing	Y	N	Kidney/Liver Disease	Y	N
Abnormal Clotting	Y	N	Diabetes	Y	N	Auto Immune Disorder	Y	N
Herpes	Y	N	Dizziness/fainting	Y	N	Arrhythmias	Y	N
Skin Cancer	Y	N	Acne	Y	N	Pace Maker	Y	N
Cancer	Y	N	Heart Attack	Y	N	Hormone Imbalance	Y	N
Keloid Scarring	Y	N	High Blood Pressure	Y	N	Difficulty Breathing	Y	N
Epilepsy (seizures)	Y	N	Thyroid problems	Y	N	Psychological Illness	Y	N
Skin disease/lesions	Y	N	Tuberculosis	Y	N	HIV/AIDS	Y	N
Frequent Cold Sores	Y	N	Pigment changes after skin injury	Y	N	Hepatitis	Y	N
Eating Disorder	Y	N	Poor wound healing	Y	N	Hernia	Y	N

*Please explain reasons for circling yes to any of the above or please explain other conditions you have that are not listed above: ____

____

For Female clients only:

Are you taking any oral contraceptives? Y / N

Are pregnant or trying to become pregnant? Y / N

Are you lactating? Y / N

Are you experiencing any menopausal problems? Y / N Specify:____

- -

I certify that the above information is correct to the best of my knowledge. In accordance with the law, Elite Aesthetics, LLC cannot cure, treat, prevent, or diagnose any condition. These treatments are used as regimens for improving skin appearance and wellness. Information exchanged during any session should be given at my own discretion. Because certain esthetic treatments 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 the skin care specialist updated as to any changes in my health prior to any future sessions and understand that there shall be no liability on the specialist's part nor on the part of Elite Aesthetics, LLC. Should I fail to do so the skin specialist reserves the right to refuse service to anyone for any reason.

I fully understand that the specialist performs her services within the parameters of esthetics, using skin care treatments and therapies. I fully understand that the esthetics specialist is not a doctor and does not portray himself/herself to be. If I experience any pain or discomfort during the session, I will immediately inform the specialist so that the products and/or techniques may be adjusted to my level of comfort.

By signing below, I acknowledge that I have read and understand all parts of this consent/intake form, and that I have had the opportunity to ask any questions with regard to any services offered. All client information is confidential.

Signature: ________________________________ Date: _____________

If under 18: Relationship: (circle) Patient Spouse Parent Guardian Signature:______________________________

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Practice Policy:

A Credit Card Number is required to reserve your appointment. We require a minimum of 24 hours notice for appointment cancellations or reschedules. If you cancel or reschedule your appointment with less than 24 hours notice or fail to show to your appointment, a $50 charge will be applied to your credit card.

We require payment in full at the time that services are rendered, or products are purchased. Accepted forms of payment are: Visa, MasterCard, Discover, American Express, Care Credit (minimum purchase amounts may apply), or Bank Certified Check. Please note we do NOT accept personal checks.

Photo Policy:
As a part of your care at Elite Aesthetics LLC, we take photographs for assorted reasons in order to serve you better. Photographs are taken for *identifying purposes* as well as for tracking your *treatment results*.

1.) I consent to a photograph being taken for **identifying purposes** to be used at Elite Aesthetics LLC. I understand this photo will be used for **internal purposes ONLY**, so that Elite staff may identify me upon arrival in their booking software (i.e. Booker).
☐ **YES Initials:_________** ☐ **NO Initials:___________**

2.) I consent to photographs being used for **internal marketing** (i.e. In-office before/after books) knowing that Elite staff will do their best to remove any identifying marks (black bar over eyes or tattoos, removal of jewelry, etc.).
☐ **YES Initials:_________** ☐ **NO Initials:___________**

3.) I consent to my photographs being used for **external marketing** (i.e. Website, Facebook, Instagram, etc.) knowing that Elite staff will do their best to remove any identifying marks (black bar over eyes or tattoos, removal of jewelry, etc.).
☐ **YES Initials:_________** ☐ **NO Initials:___________**

Refund Policy:
We are committed to providing excellent service along with individually customized treatments. Though we do our best to achieve your desired, realistic outcome, we do NOT issue a refund or credit after treatments are purchased or rendered.
All quotes are valid for 30 days, unless otherwise specified from time of consultation. Some procedures performed at Elite Aesthetics LLC may require a non-refundable deposit to book. Any balance remaining will be due at the time of the first appointment. Any procedures *cancelled* once the deposit is given will not be refunded back, but may be used, at the discretion of Elite Aesthetics LLC, as a facility credit towards another procedure. All facility credits must be used within 3 months from the date of purchase, unless otherwise specified.

Any deposits not used within 3 months of payment are forfeited

By signing below, I acknowledge I have read over and understand Elite Aesthetics LLC practice policies. I have had the opportunity to ask any questions regarding any policy provided by Elite Aesthetics LLC.

Signature: ____ Date: _____________

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Cosmetic Interest Questionnaire

Our mission is to provide you with a variety of treatments to fit your needs and to educate you about what services we offer. Please take a moment to fill out the below survey so we may find out what we can do to serve you better!

Patient Name:____ Date:________________

Reason for visit?:_______________________________________

Have you ever received professional skin care/esthetic treatments? Yes / No
If yes, what type:____
____

What is your current skin care regimen? What products are you using? ____
____
____

How would you rate the overall quality of your skin? (Circle One) POOR FAIR GOOD VERY GOOD EXCELLENT

What improvements would you like to see to your skin? ____
____

What services or concerns would you like to learn about? Please check all that apply.

❑ How to care for my skin	❑ Chemical Peel	❑ Double Chin
❑ Skin Rejuvenation	❑ Brown spots/age spots/freckle	❑ Abdominal Area
❑ Injectable Treatments	❑ Drooping brow	❑ Love Handles or Bra Bulge
❑ Fillers	❑ Drooping eyelids	❑ Hips
❑ Facial fine lines/wrinkles	❑ Facial fullness/drooping	❑ Thighs
❑ Thin lips	❑ Neck Wrinkles	❑ Facial Contouring
❑ Blotchy skin	❑ Length/Fullness of Eyelashes	❑ Body Contouring

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5