Lasting Impression
MEDICAL AESTHETICS

INTAKE FORM

Name: ____________________ Date: ____________________
Address: ____________________ Date of Birth: ____________________
City, State, ZIP Code: ____________________ Phone #: ____________________
Email (Please Print): ____________________ Allergies: ____________________

How did you hear about us? Please check (/ or ✔) all that apply.

☐ Friend ☐ Relative ☐ Web Search ☐ Newspaper ☐ Facebook
☐ Radio ☐ Television ☐ Email ☐ Other (Specify): ____________________

Are you pregnant or nursing? ☐ Yes ☐ No Note (Leave blank if none): ____________________

What procedure are you getting today? ____________________

What other procedures are you interested in? Please check (/ or ✔) all that apply.

Antiaging Injectables

☐ Botox ☐ Fillers ☐ Y-Lift ☐ Mesotherapy ☐ PDO Threadlift

Facial Therapy

☐ Microneedling with PRP (Vampire Facial) ☐ Microdermabrasion with Hydrating Serums
☐ Platelet Rich Plasma (PRP) Face Lift ☐ Chemical Peel

Acne Treatment

☐ Agnes Radiofrequency

Skin Tightening/Wrinkle Reduction

☐ Neogen PSR (Nitrogen Plasma Technology) ☐ Exilis Ultra 360 (Radiofrequency Technology)
☐ Sylfirm (Radiofrequency with Microneedling)

Facial Therapy

☐ Hair Reduction ☐ Pigmented Lesion Treatments
☐ Photofacial ☐ Spider Veins & Vascular Lesion Treatments

Hair Loss & Thinning

☐ Platelet Rich Plasma (PRP) Therapy

Facial Therapy

☐ Emsella ☐ Medically Supervised Weight Loss Program

PATIENT CONCERNS	
Name:	Date:
Email:	Phone:

HAIR		
Concern	**Yes**	**No**
Hair thinning?		
Hair loss?		
Issue with hair texture or brittleness?		
Hair shedding?		

Forehead/Frown Lines?			
Yes		No	

Crow's Feet?			
Yes		No	

Improve Skin/Pore Texture?			
Yes		No	

Undereye Circles/Lines/Bags?			
Yes		No	

Facial Volume Loss?			
Yes		No	

Thin/Short/Lightened Lashes?			
Yes		No	

Nose-to-Mouth Lines?			
Yes		No	

Brown Sports/Freckles?			
Yes		No	

Lips Volume Loss?			
Yes		No	

Broken Blood Vessels?			
Yes		No	

Facial Volume Loss?			
Yes		No	

Double Chin/Neck Fullness?			
Yes		No	

Thin/Short/Lightened Lashes?			
Yes		No	

Neck/Chest Discoloration?			
Yes		No	

Red Spots/Flushing?			
Yes		No	

Interested in Skin Care?			
Yes		No	

Textured/Saggy Skin?			
Yes		No	

Please add any additional concerns not listed:

Skin Care Routine

What is your daily skin care regimen? Please check (/ or ✔) all that apply.

☐ Cleanser ☐ Moisturizer ☐ SPF ☐ Retinols ☐ Creams

Other skin care products (please specify): ____________________

Skin Condition

Which of the following best describes your skin? Please check (/ or ✔) all that apply.

☐ Very Oily ☐ Large Pores ☐ Oily Skin ☐ Combination Skin

☐ Oily T-Zone ☐ Sensitive Skin ☐ Dry Skin ☐ Dry to Normal Cheeks

Sun History & Lifestyle

Please check (/ or ✔) only one box per question.

1. How often do you work outdoors?

☐ Frequently ☐ Occasionally ☐ Very Rarely

2. How often do you use sunscreen?

☐ Frequently ☐ Occasionally ☐ Very Rarely

3. How often do you use tanning beds?

☐ Frequently ☐ Occasionally ☐ Very Rarely

Have you ever worked with metals before? (Examples: Cutting / Grinding / Milling / Welding) ☐ Yes ☐ No

If yes, what kind of metal work did you do?: ____________________

Dermatologic History & Previous Procedures

Have you ever had—please check (/ or ✔) all that apply.

☐ Skin Cancer ☐ Chemical Peel ☐ Chronic Skin Conditions

☐ Photosensitivity ☐ Botox Injection ☐ Laser Skin Resurfacing

☐ Keloid Scar ☐ Accutane (Acne) ☐ Recent Waxing/Plucking

☐ Botox Injection ☐ Other Injection ☐ Dermal Filler

☐ Electrolysis ☐ Tetracycline (Acne) ☐ Pigmentation Disorder

☐ Recent Sunburn ☐ Threading ☐ Recent Tan (Tanning Bed Included)

☐ Skin Tightening ☐ Skin Rejuvenation ☐ Permanent Makeup

☐ Facials ☐ Microdermabrasion ☐ Laser Hair Reduction

☐ Cellulite Removal ☐ Skin Tightening (What Kind): ____________________

☐ Circumference Reduction ☐ Body Contouring (What Kind): ____________________

Other skin-related condition: ____________________

By signing this document, I hereby voluntarily consent to the rendering of care, including procedures deemed necessary to address the area(s) of concern(s) I specified. I hereby acknowledge:

- —that no guarantee has been made to me as to the effect of such treatment or procedure done;
- —that the side effects were discussed to me in a detailed manner.

Client Signature: ____________________ Reviewed: ____________________