ALINEA
Esthetics

Esthetics Client Intake Form

Date: _____

Personal Information:

- **Name:** _____
- **Address:** _____
- **City:** _____ **State:** _____ **Zip:** _____
- **Phone:** _____
- **E-Mail Address:** _____
- **Emergency Contact (Name & Phone):** _____
- **Primary Physician:** _____
- **Birth Date:** _____

Contact Preferences:

- Do we have permission to contact you by phone or leave messages?
    - Phone: **Yes / No**
    - Text: **Yes / No**
    - E-Mail: **Yes / No**
- Preferred method of contact: _____
- Do we have permission to show your photos for educational purposes? **Yes / No**

Skin Concerns

What concerns you most about the overall appearance of your skin? (Check all that apply)

- ☐ Acne
- ☐ Blackheads
- ☐ Bumps on back of arms
- ☐ Dehydrated Skin
- ☐ Acne Scarring
- ☐ Body Acne
- ☐ Cellulite
- ☐ Dull Complexion
- ☐ Age Spots
- ☐ Broken Blood Vessels
- ☐ Cysts/Nodules
- ☐ Facial Veins
- ☐ Large Pores
- ☐ Oily Skin
- ☐ Rosacea
- ☐ Fine Lines/Wrinkles
- ☐ Loss of Lashes/Brows
- ☐ Redness
- ☐ Sagging Skin
- ☐ Excessive Facial Hair
- ☐ Frequent Breakouts
- ☐ Melasma/Brown Spots/Patches
- ☐ Rough/Uneven Skin Texture
- ☐ Sun Damage
- ☐ Under Eye Puffiness/Dark Circles
- ☐ Other: _____

How would you describe your skin?

- ☐ Oily
- ☐ Dry
- ☐ Combination
- ☐ Sensitive

How would you describe your stress level?

- ☐ Little
- ☐ Moderate
- ☐ High
- ☐ Severe

Do you feel your stress level may be affecting the health of your skin? **Yes / No**
Are you in good health overall? **Yes / No**

Medical History

- Are you currently under the care of a physician? **Yes / No**
    - If yes, explain: _____
- Do you have any allergies to foods or medications? **Yes / No**
    - If yes, explain: _____
- Are you currently on any medications either topical or oral? **Yes / No**
    - If yes, please list: _____
- **Ethnic Background (Parents, Grandparents, and Great Grandparents):** _____
- How do you heal after an acne breakout, cut, or scratch?

    ☐ No scar ☐ Redness ☐ Brown (PIH)
- Do you smoke? **Yes / No**
- Are you prone to cold sores? **Yes / No**
    - If yes, date of last cold sore: _____
- Do you have an allergy to Latex? **Yes / No**
- Do you tan in the sun or in tanning beds/booths? **Yes / No**

Current Skincare Routine

Please check the skincare products you are currently using:

☐ Eye Cream	☐ Cleanser
☐ Sunscreen	☐ Concealer
☐ Moisturizer	☐ Serum
☐ Toner	☐ Scrub
☐ Self Tanner	☐ Makeup

Additional Notes:

_____

The answers I have provided are true and correct to the best of my knowledge.

Client Signature: _____

Date: _____

Informed Consent

I consent to receive treatment performed by a licensed Esthetician in the Alinea Services Private Member Association.

I acknowledge that there may be contraindications to this treatment, including but not limited to: diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate, or the development of keloids following injury. Certain medications, including blood thinners, higher dosages of Aspirin, and Accutane, may also be contraindications.

I certify that I am not taking any of the above medications or experiencing any of the above conditions. If

I am, I have disclosed this information, and my practitioner will make appropriate suggestions and modifications based on these contraindications. I may be asked to provide written permission from my physician before proceeding with services.

While every precaution will be taken to avoid any negative outcomes, I understand the risks and consent to treatment today.

Name: _____

Date: _____

Signature: _____