Massage Academy of the Poconos Facial Intake Form

Name: _____ Phone: _____

Address: _____ Email: _____

City: _____ State: Zip: _____ Date of Birth: _____

Emergency Contact: _____ Emergency Contact Number: _____

Skin Concerns + Wellness

1. Is this your first facial? _____ Yes _____ No

2. Are you currently under a physician's care for any current skin condition? _____ Yes _____No

3. Have you had a chemical peel, laser, or microdermabrasion treatment in the last 6 months? _____Yes _____ No

4. Do you sunbathe or use tanning booths? _____Yes _____ No

5. Are you pregnant or lactating? _____ Yes _____ No

6. Have you taken Accutane or used Retin-A, Renova, or any topical prescriptions within the last 12 months?
_____Yes _____No

7. Do you wear contact lenses? _____ Yes _____ No 8. Have you had skin cancer? _____ Yes _____ No

9. Do you smoke? _____ Yes _____ No 10. Do you have any neck or shoulder pain? _____Yes _____No

11. What are your two primary skincare goals?
Goal 1: _____ Goal 2:_____

12. What steps are you currently using in your current skin are regime? (Check all that apply and specify brand and type)

Cleanser:	Exfoliator:	Mask:	Eye Treatment:
Serum:	Toner:	Moisturizer:	Other:

What are your primary skin care concerns? Check all that apply.

□ Acne/Blemishes	□ Dehydration	□ Loss of Elasticity/ Firmness	□ Sun Damage
□ Blackheads	□ Dull Skin	□ Puffy Eyes	□ Uneven Skin Texture
□ Age Spots	□ Enlarged Pores	□ Rosacea/Redness	□ Whiteheads
□ Crows Feet	□ Fine Lines	□ Acne Scars	□ Wrinkles
□ Dark Eye Circles	□ Hyperpigmentation		

Have you ever had any sensitivities or allergic reaction to any of the following:

□ Alpha Hydroxy Acids	□ Aspirin	□ Pollen	□ Latex
□ Cosmetics	□ Fish/Marine/Iodine	□ Food/Nut	□ Sunscreen

Please check if you are affected or have any of the following:

□ Cancer/Radiation	Sores	□ Metal Bones/Pins/Plates
□ Cardiac Problems	□ High Blood Pressure	
□ Diabetes	□ Digestive Imbalance	□ Sinus Problems
□ Epilepsy	□ Immune Disorders	□ Skin Disease
□ Fever Blisters/ Cold	□ Lupus	

Please initial after agreeing to each of the following statements:

□ I have not had any microdermabrasion treatments in the last 4 weeks _____
□ I have not had any facial waxing in the last 48 hours _____
□ I have not had an cosmetic facial injections in the last 4 weeks _____
□ I have not used Accutane in the last 12 months _____
□ I have not had any chemical peels on my skin in the last 4-6 weeks _____
□ I have not had any Retin A/ Retinol topical prescriptions on my skin in the last 7 days _____
□ I have not had any facial cosmetic surgery in the last 12 weeks _____
□ I have not had any chemotherapy or radiation in the last 6 months _____

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature:_____ Date:_____

I hereby consent to and authorize the Massage Academy of the Poconos Esthetician to perform any of the following procedures: Facials, Waxing, and/or Body Treatments.

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by the Massage Academy of the Poconos Esthetician. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost. I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the Esthetician immediately. I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically. I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I understand, have read, and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received.
The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/skin care professional from liability and assume full responsibility thereof. I do not hold the Esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (Printed): _____

Client Signature _____ Date: _____

Esthetician: _____ Date: _____

As the parent or legal guardian of _____, I give permission for them to have the following services performed:_____
I confirm that I have read and understand all information on the applicable forms for this treatment or service and accept responsibility on my child's behalf for any disclosures or liability described on those forms I agree to supervise any home care

procedures that are recommended as a result of the treatment.

Date: _____
Guardian/Parent Full Name: _____
Guardian/Parent Signature: _____
Esthetician Signature: _____
This form must be signed in person by the parent/guardian at the time of service, witnessed by the Esthetician.

Waxing Consent

What is your menstrual cycle due date? _____
(Always allow five days for menstrual cycle. Because of water retention and for your own personal comfort, you should avoid hair removal two days before your cycle is due and two days after it is completed.)

Please note that waxing does have certain side effects such as skin removal, redness, swelling, tenderness, etc. I have read the information and if I have any concerns, I will address these with my Esthetician. I give permission to my Esthetician to perform the wax procedure we have discussed and will hold the Esthetician and staff harmless from any liability that may result from this treatment. I have given accurate account of the questions asked including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my Esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my Esthetician for a home-care regiment hat can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the Esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraph and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the Esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (Print): _____
Client Signature: _____ Date: _____
Esthetician: _____ Date: _____