



## Client Skin/Nails Intake Form

Date: \_\_\_\_\_

First Name (Print Please): \_\_\_\_\_ Last Name \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

1. What skincare products are you currently using? {circle all that apply}

Cleanser /Toner /Antioxidant/Moisturizer /Masque/Exfoliants/Retinol/Eye Products /Sunscreen/

Others \_\_\_\_\_

2. Please describe your daily skincare routine:

AM Routine: \_\_\_\_\_ PM Routine \_\_\_\_\_

3. Have you in the past, had any chemical peels, laser procedures, laser treatments, injections, or other aesthetic procedures?

\_\_\_\_\_

4. Have you taken Accutane in the last 6 months? \_\_\_\_\_

5. Please list any medications you take \_\_\_\_\_

6. Any Allergies, if so please list \_\_\_\_\_

7. Do you use Tretinoin, Hydroquinone, Benzoyl Peroxide or topical pharmaceuticals? \_\_\_\_\_

8. Have you experienced any of the following on your skin? {circle all that apply}

Flakiness /Tightness/ Dryness/ Oiliness/ Acne or Breakouts/ Redness /Skin Dullness/Skin Laxity /Fine Lines and Wrinkles

/Hyper pigmentation

9. Do you use an antioxidant daily? \_\_\_\_\_

10. Do you wear sunscreen daily? \_\_\_\_\_ If so, what level? \_\_\_\_\_

11. What are your top 3 skincare concerns? \_\_\_\_\_

12. Do you live in an urban area exposed to pollution? \_\_\_\_\_

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### CANCELLATION POLICY

Appointments should be cancelled 24 hours prior to service. If the appointment is cancelled after the 24 hour mark, your card on file will be charged. First time cancellation fee is \$50, second time cancellation fee is \$100, and third or more cancellation fee is the cost of the service.

Cancellation fee for Tox appointments is \$50.

Cancellation fee for filler appointments is \$100.

By signing below, you attest that you have provided accurate and current information on this form and have answered all medical and health related questions truthfully and completely. Your signature also certifies that you understand Center MedSpa reserves the right to deny service to any client due to a health condition that may pose potential risk to practitioners or other clients, including those that pose a risk of potential contamination to service areas. Signing below verifies that you understand that you are responsible for informing Center MedSpa staff of any and ALL changes to your health condition as it pertains to any question on this form or any potential public health risk that may arise from any change in your health condition and that you also understand and agree to our cancellation policy.

\_\_\_\_\_  
Patient Name - Print

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

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