3519 West 70th St Suite 20 Edina, MN 55435
www.revealsacredskincare.com 952-486-3079

CLIENT INTAKE FORM

CONTACT INFO

Name_____ Date of Birth_____
Address_____
City/State_____Zip_____
Email_____Phone_____
How did you hear about us? _____

HEALTH, NUTRITION AND LIFESTYLE INFO

Do you have known allergies? Y/N
Please List:_____
Are you currently being treated by a physician? Y/N
If yes, for what?_____
Please list ANY medications you are taking, including supplements, *topicals* and OTC:
_____
Do any of these medications have photosensitivity listed as a side effect? Y/~~/~~N
Do you have any metal implants or a pacemaker? Y/N
Do you have a history of seizures? Y/N
How many hours of sleep do you get/night?_____
Do you smoke? Y/N
How many oz of water do you drink/day?_____
How many caffeinated beverages/ day?_____
Do you drink alcohol? How many drinks/week?_____
Are you pregnant or nursing? Y/N

On a scale of 1-10, rate your stress level?_____

Do you have any contagious illnesses? Y/N
Have you ever been diagnosed with cancer? Y/N
If yes, what?_____

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Do you move your body on a regular basis? Y/N
If so, how and how often?_____

Do you have dietary restrictions? Y/N
If so, what are they?_____

SKIN INFO

What is your intention in seeking my services? Circle all that apply or use your own words:
_____
_____

Relax Feel Beautiful in my skin Visible Results Learn how to care for my skin
What products are you currently using? Circle all that apply:
Makeup Remover Cleanser Toner Serum Moisturizer Sun Protection Eye Cream
Mask Exfoliant Retinol Prescription Topical Soap Shower Gel Body Lotion

Devices (clarisonic,etc):_____
_____
Other:_____
If known, Brands:_____

What skin type do you feel you have?
Oily Acne Combination Sensitive Dry Mature

Does your skin burn easily? Y-/-N
Do you use tanning beds? Y-/-N

Reveal
SACRED SKINCARE

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CONSENT AND POLICIES

By signing, I confirm that I understand the questions asked and information given are confidential and relevant to my treatment and that, to the best of my knowledge, my answers are accurate.

INITIAL___SKIN TREATMENT SIDE EFFECTS: I understand that possible side effects to skin treatments are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples/purging, cold sores or allergic reactions. Most effects are temporary and will dissipate within 3-7 days.

INITIAL___HAIR REMOVAL SIDE EFFECTS: I understand that possible side effects to hair removal are not limited to tenderness and swelling, ingrown hairs, breakouts, bruising, tissue lifting and crusting. Healthy skin prior to waxing and suggested home care is essential to minimize these occurrences and their severity.

INITIAL____CLIENT COMMUNICATION: I will contact my service provider with any questions, complications or concerns.

INITIAL_____CLIENT RESPONSIBILITY: I understand that it is my responsibility to keep my service provider informed and updated should any of the above information change.

INITIAL____CANCELLATION POLICY: I understand that I need to cancel or reschedule my appointments at least 24 hours in advance or I will be charged in full for my missed services, regardless of circumstances.

Signature_____Date _____