THEBROWCLINIC

CLIENT DETAILS

(THE INFORMATION SUPPLIED BELOW IS CONFIDENTIAL AND FOR PROFESSIONAL USE ONLY)

NAME:				DATE:	
ADDRESS:				DOB:	
HOME:		MOBILE:		EMAIL:	

Name of Service to Be Performed: _____ How did you hear about us? _____

ARE YOU CURRENTLY USING OR TAKING?	YES	NO	ARE YOU CURRENTLY USING OR TAKING?	YES	NO	ARE YOU CURRENTLY USING OR TAKING?	YES	NO
Accutane, Isotretinoin (within 12 months)			Chemical Peels			Hormone Replacement		
Drugs or Alcohol in the last 24 hours			Steroids or Immunosuppressant			Blood thinning medication or daily Aspirin		
Retin A / Renova			Retinols in skin care			Acne medication or Vitamin A derivatives		
Cigarettes			Latisse or lash and brow serums			Contraceptives		
Prescription Pain Killers			Antibiotics within 2 weeks			Mood Altering Medication		
Glycolics, Beta or Alpha Hydroxy Acids			Tanning in the past 2 weeks			Contact Lenses		

HEALTH INFORMATION	YES	NO	HEALTH INFORMATION	YES	NO	HEALTH INFORMATION	YES	NO
Anemia			Seizures or Epilepsy			Keloids		
Trichotilomania			Eczema			Glaucoma		
Thyroid Issues			Pacemaker			Autoimmune Disorders		
HIV /Aids			Pregnant or nursing			Claustrophobia		
Liver Disease			Psoriasis			Ocular Herpes		
Circulatory Problems			Current or Recent Cancer Treatment			Hypo -Pigmentation		
Diabetes			Cold Sores / Fever Blisters			Problems Healing		
High / Low Blood Pressure			Rosacea			Dry Eyes		
Hemophilia / bleeding disorder			Staph / MRSA			Hyper Pigmentation		
Heart problems			Herpes Virus					

Are you under the care of a Physician or Dermatologist? □ YES □ NO

Are you required to take a course of antibiotics for any minor dental or medical procedures? □ YES □ NO

List any medications, supplements, vitamins or herbs that you take regularly:

Do you have allergies or sensitivities to (circle all that apply)?

Latex Products containing "-Caine" Medications Nickel or other metals

Petroleum products Fragrances Skin Care or Ointments Essential Oils

List all known allergies and reactions:

Have you received Botox/Dysport or fillers such as Juvederm/Restylane treatments in the past 30 days? □ YES □ NO
If yes, when? What areas?

Have you received a chemical peel, microdermabrasion, IPL, laser or other facial treatment in the past 30 days?
□ YES □ NO
If yes, when?

How often are you exposed to the sun, whether during work or at play?

How often do you wear sunblock?

What do you believe best describes your skin type? (circle all that apply): Dry Normal Combination Oily Sensitive

Is there anything else we need to know about you in order to better service your needs?

Thank you for taking the time to complete this client intake form. All of the information above is extremely helpful to provide the best care for you and ensure your safety during the procedure.

READ AND INITIAL THE BELOW:

I understand that full disclosure of my past and current health history is in my best interest to ensure a safe procedure and that I have honestly disclosed such information. (initial) _____

I understand if I change my skin care routine or medications, or my health condition changes, I must inform the professional PRIOR to any service in the future. (initial) _____

I understand that if I have health or medication contraindications the technician may require a written release from my Physician before proceeding with any procedure. (initial) _____

Today's Date: _____/_____/_____ Client's Printed Name: _____

Client's Signature: _____

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