Beauty Bungalow
1717 9th Street North
St. Petersburg, FL 33704

Client Intake Form

Name: _____Date of Birth: _____

Address: _____

Cell Phone: _____Email:_____

Referred by:_____ Emergency Contact:_____#_____

What would you like to change/improve/achieve with your treatment today?_____

_____

Have you had a facial treatment before? ☐ Yes ☐ No Date:_____

Have you undergone chemical peels, laser treatments, or microdermabrasion? ☐ Yes ☐ No Date: _____

Do you use a Retin-A, Renova, Adapalene Hydroxyl Acid, Acutane or any other Vitamin A derivative product? ☐ Yes ☐ No

Have you ever had an allergic reaction or negative reaction to any of the following (check all that apply):

☐Airborne Pathogens	☐Sunscreen or PABA	☐Fragrance
☐Medications	☐Metal	☐Iodine
☐Topical Solutions	☐Foods	☐Cosmetics
☐Latex Rubber	☐Other _____	

Describe reaction: _____

Do you have any skin problems or dermatological disorders?_____

Have you recently used any self tanning lotions or tanning beds?_____

What SPF do you use on your face? How often?_____

Does your job require you to be outside?_____

Have you used any hair removal methods on your face in the last six weeks?_____

Do you use any acne medication?_____

What skin care products are you currently using (check all that apply):

☐Cleanser_____	☐Eye Cream_____	☐Soap_____
☐Toner_____	☐Sunscreen_____	☐Makeup_____
☐Moisturizer_____	☐Night Cream_____	☐Other_____

What areas of concern do you have regarding your skin (check all that apply):

☐Breakouts/Acne	☐Redness	☐Wrinkles/Fine Lines
☐Excessive Oil	☐Sunspot/Brown Spot	☐Dry Skin
☐Rosacea	☐Uneven Skin Tone	☐Flaky Skin
☐Broken Capillaries	☐Sun Damage	☐Dehydrated

General Medical History (check all that apply):

☐High Blood Pressure	☐Hepatitis	☐Cancer
☐Diabetes	☐Brain injury	☐Gallstones
☐Blood Thinners/Anticoagulants	☐Seizures/Epilepsy	☐Liver Disease
☐Hemophilia/Clotting Disorder	☐Autoimmune Disorder	☐Infectious Disease
☐Mitral Valve Prolapse/ Implants	☐Shingles	☐Cold Sores
☐Heart Palpitations	☐Metal Implants/Pacemaker	☐Unbalanced blood pressure

List surgeries you have had (last 6 months) or plan to have (next 6 months):_____

List medications, prescriptions, and non-prescriptions (including herbal supplements) that you have taken and or applied to skin in the last two weeks?_____

Are you currently under a physicians care for any condition? ☐ Yes _____ ☐ No

Physicians Name:_____

Female Clients:

Do you take contraceptives? ☐ Yes ☐ No

Any recent changes to contraception?_____

Are you pregnant or trying to conceive? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Are you Peri/Post Menopausal? ☐ Yes ☐ No

Any menopausal issues? _____

Are you undergoing hormone replacement therapy? ☐ Yes ☐ No

Male Clients:

What is your current shaving system?_____

Do you experience post shave irritation? ☐ Yes ☐ No Ingrown hairs? ☐ Yes ☐ No

May we call or text you to confirm future appointments? ☐ Yes ☐ No

May we contact you via mail/email about future promotions and news? ☐ Yes ☐ No

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 the Beauty Bungalow and its skincare professionals from liability and assume full responsibility thereof.

Client Signature_____ Date_____