TOTAL BODY AFFINITY

Skin In-Take Form

dermalogica
developed by The International Dermal Institute

Date_____

Full Name:			**DOB:**
Address:	**City:**	**State:**	**ZIP**
Home phone number: ( )	**Cell:** ( )	**Work** ( )	**Email Address:**
May we contact you via phone/mail/email about future appointments, promotions and news? Contact preference: ☐ **Email** ☐ **Text** ☐ **Telephone**	**Were you referred to Total Body Affinity by an existing client?** ☐ **Yes please tell us who:** ☐ **No** ☐ **Groupon Voucher #_____ Date used_____**		

EMERGENCY CONTACT INFORMATION

Name	**Relationship**	**Phone number** ( )

SKIN CARE AND HEALTH CONDITIONS

1) Have you ever had a facial treatment before? Yes No, when? _____

2) Are you wearing contact lenses? Yes No

3) Have you ever had chemical peels, laser or microdermabrasion? Yes No In the last month? Yes No

4) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? Yes No

5) Have you used any of these products in the last 3 months? Yes No

6) Have you used any of the following hair removal methods in the past six weeks? Yes No, circle all that apply:

Shaving Waxing Electrolysis Plucking Tweezing Threading Depilatories

7) Are you currently under a physicians care for any skin conditions? Yes No

Describe:_____

8) Do you have any health problems or concerns that we need to be aware of before we begin this treatment? ***(Including recent surgery, pace maker, bone pins, etc.)*** Yes No

Specify:_____

9) Do you have any known allergies ***(Nuts, essential oils, foods, medications, skin care products)***? Yes No

10) Do you smoke? Yes No

CONCERNS

11) What areas of concern do you have regarding your:

Skin: (Please check all that apply)

Breakouts/acne ____ Dull/dry skin/flaky skin ____ Dark Circles/Puffy Eyes ____
Blackheads/whiteheads ____ Sun spots/liver spots/brown spots ____ Dry/Cracked Lips ____
Excessive oil/shine ____ Uneven skin tone ____
Rosacea/ Redness ____ Wrinkles/fine lines ____

12) What skin care products are you currently using? (List brand where known)

FEMALE CLIENTS ONLY

13) Are you taking any oral contraceptives? Yes No, specify:_____

14) Are you pregnant or trying to become pregnant? Yes No

15) Are you experiencing any menopausal problems? Yes No

Specify: _____

LIABILITY WAIVER

I understand, have read and completed this questionnaire truthfully and to the best of my knowledge and I will update Total Body Affinity of any changes. I agree that this constitutes full disclosure, and that it supersedes any precious 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 skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____ Esthetician: _____

Client Signature: _____ Date: _____ Esthetician: _____

Client Signature: _____ Date: _____ Esthetician: _____

Client Signature: _____ Date: _____ Esthetician: _____

Client Signature: _____ Date: _____ Esthetician: _____

Client Signature: _____ Date: _____ Esthetician: _____