Infinite Skin
Aesthetic Medical Spa

1665 43rd St S
Suite 108
Fargo, ND 58103
701-282-9642

Client Intake Form

General Information

Name: _____ Today's Date: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Date of Birth: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

How did you hear about us? _____

If referred from a client please list their name so we can thank them! _____

Skin History

Concerns *(Check all that apply):*

◯ Acne/Acne Scarring	◯ Unwanted Hair	◯ Skin Laxity
◯ Brown Spots/Sun Damage	◯ Pigmented Lesions	◯ Skin Texture/Scars
◯ Rosacea	◯ Flushing of the skin	◯ Fine lines/Wrinkles
◯ Melasma	◯ Crow's Feet	◯ Dry Skin
◯ Large Pores	◯ Deep Lines/Shadows	◯ Oily Skin

How long have you had any of the above concerns? _____

Do you feel these conditions are worsening? **Y** **N** If Yes, explain_____

Are you currently being treated for any of the above conditions? **Y** **N**
If *yes*, please explain: _____

Are you currently taking any medications for a skin condition? **Y** **N**
If yes please list: _____

Have you or anyone in your family had skin cancer? **Y** **N**
If *yes*, please explain: _____

Have you had a reaction to lotions, creams, or oils? **Y** **N**

If *yes*, please explain: _____

Personal History:

Do you smoke? **Y** **N**
Do you drink alcohol? **Y** **N**
Do you wear Contact Lenses? **Y** **N**
Do you exercise regularly? **Y** **N**
Do you have any metal implants? **Y** **N**

Medical History

*Please check **ALL** that apply to you:*

◯ Active Infection	◯ Cancer	◯ Hepatitis A, B or C	◯ Pacemaker/Defibrillator
◯ Alcoholism	◯ Chemical Dependency	◯ Herpes	◯ Pigmentation disorder
◯ Anemia	◯ Chest Pain	◯ High Blood Pressure	◯ Polycystic ovaries (PCOS)
◯ Anorexia	◯ Chronic Fatigue	◯ Hormone Imbalance	◯ Sensitive Teeth
◯ Arthritis	◯ Connective Tissue Disorder	◯ HIV/Aids	◯ Skin Cancer/Moles
◯ Asthma	◯ Diabetes	◯ Keloid Scarring	◯ Skin Injury/Lesions
◯ Autoimmune Disease	◯ Eating Disorders	◯ Migraines	◯ Thyroid Disorders
◯ Bleeding Disorders	◯ Epilepsy or seizures	◯ Multiple Sclerosis	◯ Vision Deficits
◯ Breast Lump	◯ Fibromyalgia	◯ Neurologic Disorder	
◯ Bruising	◯ Heart Disease	◯ Neuromuscular Disorder	

Are you taking any blood thinners? **Y** **N** Do you take Aspirin or Ibuprofen? **Y** **N**

Are you taking any supplements? (Vitamin E, Fish Oil, etc.) _____

Please list **ANY** Medications you are taking:

_____

_____

Please list **ANY** allergies: _____

Are you pregnant or planning to become pregnant? **Y** **N** Are you nursing? **Y** **N**

Do you have any muscle issues (i.e. Strokes, Bell's Palsy, nerve injury)? **Y** **N**
If *yes*, please explain: _____

Please list any surgeries and dates of surgery:

_____

_____

Cosmetic History

Have you ever had Botox and/or Filler treatments? **Y** **N**

Have you had a reaction to ANY cosmetic procedure? (i.e. Botox, Fillers, Lasers, Chemical Peels)
If *yes*, please explain: _____

Is there ANY other information you would like your technician to be aware of?

_____

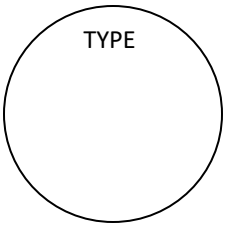
I have answered the questions contained in this questionnaire to the best of my knowledge. I understand it is my responsibility to inform my technician of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes to my health between treatments.

_____ _____

Client Signature Date

SCORE		0	1	2	3	4
	What is your natural hair color?	Sandy Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black
	What is the color of your eyes?	Light Blue, Gray, Green	Blue, Gray, Green	Brown	Dark Brown	Brownish/Black
	What is the color of UNEXPOSED skin areas?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
	How many freckles on UNEXPOSED skin areas?	Many	Several	Few	Incidental	None
	What happens when you are in the sun too long WITHOUT sunblock?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never has been a problem
	How well do you turn brown?	Hardly or not at all	Light tan color	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond in the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
	TOTAL					

00-07 Points = Skin Type I
08-16 Points = Skin Type II
17-25 Points = Skin Type III
26-30 Points = Skin Type IV
31-40 Points = Skin Type V & VI



Cancellation and Late Policy

The most valuable thing you can give someone is your time, and we fully believe that everyone's time should be respected. We understand sometimes it is necessary to reschedule or cancel an appointment; however, we ask that 24 hours notice is given prior to cancelling. **In the event that you are unable to give us a 24 hours notice, a cancellation or "No Show" fee of $50 will be charged to your card.** If you arrive more than 10 minutes late to your scheduled appointment, we have the right to ask you to reschedule. We apologize for any inconvenience this may cause.

_____ _____

Client Signature Date

Office use only

Reviewed By:

_____	_____	_____
R.N. Name	R.N. Signature	Date

_____	_____	_____
Medical Provider Name	Medical Provider Signature	Date

Office Notes: _____

_____

_____

The above client has been evaluated & may receive the following treatments per treatment protocol:

- ☐ Neurotoxin
- ☐ Dermal Fillers
- ☐ Latisse
- ☐ Laser Based Treatments
- ☐ Chemical Peels
- ☐ Micro needling
- ☐ B12 Injections
- ☐ Body Contouring Services
- ☐ Dermaplaning
- ☐ Light Therapy Treatments