Client Intake Form

Date _____

Name_____

Date of Birth_____ Age_____

Address_____

City, State, Zip_____

Phone_____

Email_____

Occupation_____

Do you work outside? Yes No

Referred by_____

Emergency Contact_____ Relationship_____

Phone(s)_____

Your Skin Care

Have you ever had a facial treatment before? Yes No

If so, what and when (most recent date)?_____

Do you have any special skin problems or concerns pertaining to your face or body? Yes No

If so, please specify_____

Which of the following best describes your skin type? Please circle one:

Always burns, never tans Mostly burns, tans slightly

Burns moderately, tans gradually Seldom burns, always tans well

Rarely burns, deep tan Never burns, deeply pigmented

Have you ever had any of the following? Please circle all that apply:

Chemical Peel Microdermabrasion Dermaplaning Laser Treatment

Within the last month? Yes No

Do you use Retin-A, Renova or Retinol? Yes No

Have you used an oral acne medication? Yes No Which one?_____

Is so, when was last use? _____

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

Breakouts/acne

Blackheads/whiteheads

Excessive oil/shine

Rosacea

Broken capillaries

Redness/ruddiness

Sun spots/liver spots/brown spots/hyperpigmentation

Uneven skin tone

Sun damage

Wrinkles/fine lines

Dull/dry skin

Flaky skin

Dehydrated skin Other_____

Eyes: Dehydrated/dry Wrinkles Puffiness Dark circles

Lips: Dehydrated, dry Chapped/cracked Other_____

Have you ever had an allergic reaction to any of the following? (Please circle all that apply)

Cosmetics Medicine/Drugs Food Animals Sunscreens Skin antiseptics Pollen

Alpha Hydroxy Acids Fragrance Shellfish Latex Others_____

Do you use SPF on your face? Yes No Do you use on your body? Yes No

Have you ever used Botox or any dermal filler? Yes No

If so, when and what type?_____

Female clients only:

Are you taking oral contraceptives? Yes No

Are you undergoing hormone replacement therapy? Yes No

Are you pregnant or trying to get pregnant? Yes No

Are you lactating? Yes No

Any menopause issues? Yes No

If yes, please specify_____

Male clients only:

What is your current shaving system? Wet Shave Electric

Do you experience irritation from shaving? Yes No Ingrown hairs? Yes No

Your contact and scheduling

May we email/text you to confirm future appointments? Yes No

Preferred method of contact: Email Text

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

May we use your before and after pictures on our social media pages – full likeness OR anonymous OR not at all (Please circle one)

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 Bo by Yas, LLC and or the skin care professional performing the services/treatments from liability and assume full responsibility thereof, (see arbitration agreement).

Client Signature_____

Date_____