SHOW ME WHAT YOU LOVE
CLIENT INTAKE FORM

Please read carefully. Complete and date this form prior to your appointment and email back to me. I'll have you sign it at your appointment. All information will remain personal and confidential.

PERSONAL INFORMATION

Date: _____

Name: _____

Address: _____

City/Province: _____ Postal Code: _____

Date of Birth: _____ Age: _____

Phone: _____ Email: _____

Occupation: _____

How did you hear about Show Me What You Love? _____

Would you like to know in advance of special offers, new products or services from Show Me What You Love?

☐ YES ☐ NO

ESTHETICS INFORMATION

What do you like about your skin? _____

_____

_____

What type of skin do you think you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination

Have you had a facial before? ☐ YES ☐ NO If yes, when was the last one? _____

How does your skin react to the sun without sunscreen? _____

Do you or have you experienced frequent blemishes? ☐ YES ☐ NO if so, how frequently? _____

What area(s) of concern do you have regarding your skin? Check any or all that apply.

☐ Breakouts/Acne ☐ Blackheads/Whiteheads ☐ Uneven Skin Tone ☐ Sun Damage

☐ Excessive Oil/Shine ☐ Wrinkles/Fine Lines ☐ Dull/Dry Skin ☐ Rosacea

☐ Broken Capillaries ☐ Redness/Ruddiness ☐ Dehydrated ☐ Sun, Liver, Brown Spots

☐ Acne Scarring ☐ Pore Size ☐ Melasma

Other: _____

Are you currently using any of the following products? What brands and how often (1-2x daily, 1x week etc.)?

☐ Cleanser _____

☐ Toner _____

☐ Exfoliate/Scrub _____

☐ Mask _____

☐ Moisturizer _____

☐ Sunscreen _____

Do you feel the skincare you have been using are giving you the results you desire? ☐ YES ☐ NO

Have you been under the care of a dermatologist within the past year? ☐ YES ☐ NO

If yes, are you, or have you been, prescribed to use / take any of the following:

☐ Acne medication ☐ Vitamin A therapies
☐ Products containing hydroquinone ☐ Products containing Alpha Hydroxyl Acids

Have you had any of the following procedures? If so, how long ago?

☐ Laser Resurfacing: _____

☐ Chemical Peels: _____

☐ Botox or other injections: _____

☐ Other: _____

On a scale of 1 to 10, what is the level of involvement to your skin health that you are willing to commit to?_____

HEALTH HISTORY

How is your general health? _____

What is your ethnic background? (Parents, grandparents, great grandparents) _____

What medications are you taking and for what conditions?

Medication _____ Reason _____

Medication _____ Reason _____

What supplements/ vitamins are you taking and for what conditions?

Supplements _____ Reason _____

Supplements _____ Reason _____

Have you ever had an allergic reaction to any of the following?

☐ Cosmetics ☐ Medicine ☐ Food ☐ Animals ☐ Sunscreen ☐ Drugs
☐ Iodine ☐ Pollen ☐ AHAs ☐ Fragrance ☐ Shellfish ☐ Latex ☐ Metals
☐ Other: _____

Please list details of reaction: _____

_____

Are you: ☐ pregnant ☐ taking birth control ☐ taking hormone replacement

LIFESTYLE

On a scale of 1 to 10 where would you rate your normal level of stress? _____

Do you drink coffee, tea, soda? ☐ YES ☐ NO If so, how many cups per day? _____

Are you on a special diet? ☐ YES ☐ NO Describe: _____

Do you smoke? ☐ YES ☐ NO

Do you consume water daily? ☐ YES ☐ NO If yes, how much? _____

Do you consume alcohol? ☐ YES ☐ NO If yes, how much? _____

Do you exercise? ☐ YES ☐ NO If yes, how often? _____

Do you experience headaches/migraines? ☐ YES ☐ NO Frequency? _____

Average number of hours spent in front of a screen per day (computer/tv/video games)? _____

Is there anything else I should be aware of that I have not already asked? _____

What do you hope to gain from our time together today? _____

ACCEPTANCE

I confirm that all the information given above is correct to my best knowledge. I take it upon myself to keep the Therapist updated on my health. I understand that the therapist does not diagnose, prevent or treat illness, disease or any other physical or mental conditions. I understand that this treatment is not a substitute for medical treatments and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental condition that I may have. I understand that this treatment is not a substitute for medical care. I hold Samantha Schneider harmless for any injuries or negative effects I may experience as a result of having the treatments done on me during the course of my treatment plan, or using the products I receive during this consultation.

_____ _____

CLIENT SIGNATURE DATE

CANCELLATION POLICY

As the space is reserved exclusively for you, please allow 48 hours' notice to cancel or amend any reserved treatment or reschedule of your appointment. Cancellation or rescheduling outside of this time will be charged 50% of the full treatment fee. If less than 4 hours' notice is given, 100% of the full treatment fee will be charged. No refunds will be given for deposits, cancellations or gift certificates purchased with less than 4 hours' notice. The owner reserves the right to make the final decision on this policy.