OMNI
BALANCED LIFE CENTER
Traditional & Holistic Therapeutic Services

Date_____

Client Skin Care Intake

If previously filled out this form: Any changes since last visit? No _____ Yes: please indicate changes on form
Initial

Name:_____ Gender: M F Age:_____ Date of Birth:_____

Address:_____ City:_____State:_____Zip_____

Preferred contact number:_____ Email:_____

May we leave a message if we do not reach you personally? Yes No

What are your top 3 concerns at this time?

1._____ 2._____ 3._____

Medical History:

Pregnant? Yes No Maybe N/A Breastfeeding? Yes No N/A Do you Smoke? Yes No

Health conditions:_____

Past Surgeries:_____

Have you ever been diagnosed with Cancer? No Yes: Date of last treatment:_____

Current Medications:_____

Prescription Topicals:_____

Allergies (include aspririn/iodine):_____

Previous Treatments:

Facials:	Yes No	Last treatment:_____	Any complications?_____	
Microdermabrasion:	Yes No	Last treatment:_____	Any complications?_____	
Chemical Peels:	Yes No	Last treatment:_____	Any complications?_____	
Waxing:	Yes No	Last treatment:_____	Any complications?_____	
Tanning:	Yes No	Last treatment:_____	Any complications?_____	
Laser Therapy:	Yes No	Last treatment:_____	Any Complications?_____	
Massage:	Yes No	Last treatment:_____	Preferred Pressure: Light Medium Deep	

Skin Conditions: (please circle the Items below that pertain to you)

Skin Infection	Herpes (cold sores)	Keloids/Excessive Scarring	Sun Sensitivity
Skin Cancer	Poor Healing	Tattoos/Permanent Makeup	Easy Bruising
Eczema	Psoriasis	Lymph Nodes Removed	Diabetes

Other:_____

Skincare: What type of skin do you feel you have? Dry Oily Normal Combination Sensitive

What is your skin routine? (Indicate any cleansers, toners, serums, moisturizers, masks, sunscreens, etc.)

1._____ 4._____

2. _____ 5. _____

3. _____ 6. _____

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Date:_____

Client Treatment Consent

Client Name:_____

Please Initial:

_____ I agree that the nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

_____ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_____ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_____ I do not have active cold sores.

_____ I will call to inform my skincare professional of any complications or concerns I may have as soon as they occur.

_____ I understand that it is recommended prior to having a facial infusion to not have used Retin A for 72 hours, Accutane in 6 months, or have waxed 24 hours prior to receiving treatment.

I consent to and authorize treatment and that the information is accurate to the best of my knowledge.

_____ _____
Client Signature Date

Technician Notes:
Treatment Receiving Today (check one):

_____Medi-Facial:_____

_____Facial Infusion:_____

_____Medi-Infusion:_____

Notes:

I have reviewed the treatment and post care instructions to the client stated above and answered any questions:

_____ _____
Technician Signature Date