Serenity Day Spa

SKINCARE INTAKE

Name:_____ Date of Visit:_____
Phone Number:_____ Email:_____
Date of Birth:_____ Occupation:_____

Are you taking any medications? If so, please list:

_____

Please List Any Allergies You Have:

_____

Please Indicate if any of the following apply to you:
(Circle all that apply)

Blackheads/ Acne/ Excessive Oil or Shine/ Broken Capillaries/ Uneven Skin Tone/ Dull or Dry Skin/ Dehydrated/ Rosacea/ Sun Damage/ Brown Spots/ Wrinkles and Fine Lines/ Whiteheads/ Redness

Please Explain any of the above conditions:

_____
_____

Have you ever had a Professional Facial Before?
YES/ NO

Have you ever had a reaction to any of the following?
Cosmetics/ Medicine/ Food/ Animals/ Sunscreen/ Drugs/ Iodine/ Pollen/ AHAs/ Fragrance/ Shellfish/ Latex

What Skin Type Do You Have?

Normal/ Dry/ Dehydrated/ Oily/ Combination

Is There Anything Specific You Want Your Esthetician To Know?

_____

What Skincare Line Are You Currently Using?

_____

Client Signature:_____
Esthetician Signature:_____