



VIDA ARTISTRY /ANDREIA
PHONE NUMBER: 908-258-7333
VIDA.ARTISTRY@GMAIL.COM
WWW.VIDAARTISTRY.COM

FACIAL TREATMENT

INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____
Date of birth: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Emergency contact: _____ Phone #: _____
How did you hear about us? _____

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- | | | |
|---------------------------------------|---|--|
| <input type="radio"/> Acne | <input type="radio"/> Herpes | <input type="radio"/> Low blood pressure |
| <input type="radio"/> Arthritis | <input type="radio"/> Hepatitis | <input type="radio"/> Lupus |
| <input type="radio"/> Asthma | <input type="radio"/> High blood pressure | <input type="radio"/> Metal bone pins/plates |
| <input type="radio"/> Blood disorder | <input type="radio"/> HIV/AIDS | <input type="radio"/> Phlebitis, blood clots |
| <input type="radio"/> Cancer | <input type="radio"/> Hyper pigmentation | <input type="radio"/> Seizure disorder |
| <input type="radio"/> Diabetes | <input type="radio"/> Hypo pigmentation | <input type="radio"/> Skin disease/lesions |
| <input type="radio"/> Eczema | <input type="radio"/> Hysterectomy | <input type="radio"/> Seborrhea |
| <input type="radio"/> Epilepsy | <input type="radio"/> Immune disorders | <input type="radio"/> Thyroid condition |
| <input type="radio"/> Fever blisters | <input type="radio"/> Insomnia | <input type="radio"/> Varicose veins |
| <input type="radio"/> Heart condition | <input type="radio"/> Keloid scarring | <input type="radio"/> Warts |

Any other condition: _____

Any known allergies? No Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

Any recent surgery, including plastic surgery? No Yes, explain: _____

♀ Are you pregnant or trying to become pregnant? No Yes

Have you ever had a facial treatment before? No Yes

If yes, please explain: _____

What changes would you like to see in your skin?

SKIN CARE

Please Check Current Products You Use:

- | | | |
|--|-----------------------------------|------------------------------------|
| <input type="radio"/> Eye Make-Up Remover | <input type="radio"/> Eye Cream | <input type="radio"/> Mask |
| <input type="radio"/> Cleanser | <input type="radio"/> Day Cream | <input type="radio"/> Facial Scrub |
| <input type="radio"/> Cleansing Oil | <input type="radio"/> Night Cream | <input type="radio"/> Exfoliants |
| <input type="radio"/> Skin Toner/ Astringent | <input type="radio"/> Neck lotion | <input type="radio"/> Body Lotion |
| <input type="radio"/> Body Soap | <input type="radio"/> Hand cream | <input type="radio"/> Body Scrub |

SKIN HISTORY

- What is your skin type? Normal Oily Dry Combo Unsure
- Your exposure to the sun? Never Sometimes Often Excessive
- How often do you wear foundation? Never Rarely 1-2/week Everyday
- How does your skin heal? Fast Slow Scars Pigments
- Do you get bruises easily? No Yes

SKIN CONCERNS

- | | | | |
|--|---|---------------------------------|-------------------------------------|
| <input type="radio"/> Acne | <input type="radio"/> Dryness/Dull Skin | <input type="radio"/> Milia | <input type="radio"/> Sensitivity |
| <input type="radio"/> Blackheads | <input type="radio"/> Eczema | <input type="radio"/> Oily Skin | <input type="radio"/> Sun Damage |
| <input type="radio"/> Broken Capillaries | <input type="radio"/> Fine lines/Wrinkles | <input type="radio"/> Psoriasis | <input type="radio"/> Thin Skin |
| <input type="radio"/> Comedones | <input type="radio"/> Hyper pigmentation | <input type="radio"/> Redness | <input type="radio"/> Unwanted Hair |
| <input type="radio"/> Cherry Angioma | <input type="radio"/> Hypo pigmentation | <input type="radio"/> Rosacea | <input type="radio"/> Other: |
| <input type="radio"/> Discoloration | <input type="radio"/> Keloids | <input type="radio"/> Scarring | _____ |

WHAT STEPS CAN WE TAKE TO MAKE YOUR APPOINTMENT WITH US EXCEPTIONAL?

Do you have any sensitivity to fragrances, such as essential oils, candles, or room sprays? No Yes: _____

Among the following music options, which one do you prefer?

- Ambient Sleep Traditional Spa Chill House Classical

Our top priority is to ensure that you receive the most comfortable and relaxing treatment possible. We provide a variety of massages to achieve this. However, to tailor your experience to your preferences, please let us know if there are any areas of your body where you would prefer NOT to receive a massage. I.E. Hands, Scalp, Chest, Neck, Shoulders: _____

As a general inquiry, would you prefer the bed heater to be turned on for each appointment? Please note that this can always be adjusted on the day of your visit. No Yes:

Do you have any other preferences or adjustments that we can make to ensure that your experience is the best possible? _____

Please note that all preferences are subject to change. Kindly inform your service provider of any modifications you wish to make.

Have you ever used acne medication? No Yes

If yes, when? _____ Which drug? _____

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? No Yes, please describe: _____

Have you received Botox, Restylane, or Collagen injections in the last 6 months? No Yes, please describe: _____

Are you allergic to citric fruits (oranges, limes, grapefruits, lemons)? No Yes, please describe: _____

Are you allergic to cocoa, chocolate, and/or raspberry? No Yes, please describe: _____

Allergic to Pineapple and/or Papaya? No Yes, please describe: _____

**** For Dermaplaning Facials ****

Have you ever done dermaplaning? No Yes, when? : _____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history.

Client Name (printed)

Date

Client Name (signature)

Date

WE LOOK FORWARD TO WORKING WITH YOU!



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SKIN ANALYSIS FORM

Client Name: _____ Date: _____

Date of birth: _____ Age: _____

Phone: _____ Email: _____

SKIN ANALYSIS

Skin type:

- Normal Oily Dry Sensitive
 Combination

Pores:

- Fine Dilated Comedones Milia

Moisture content:

- Excellent Good Fair Poor

Elasticity:

- Excellent Good Fair Poor

Acne:

- No
 I II III IV

Skin sensitivity:

- Normal Sensitive Hyper sensitive

Fine lines (Glogau scale):

- I - None II - Wrinkles in motion
 III - Wrinkles at rest IV - Mostly wrinkles

Known allergies:

Medications:

Previous treatments:

Life style:

- Active Sedentary

NOTES



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CLIENT CONSENT FORM

I hereby consent to and authorize _____ to perform the following procedure: _____.

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by:

_____.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed)

Client Name (signature)

Date

Esthetician (signature)

Date



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PHOTO & VIDEO RELEASE FORM

I, _____ hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and /or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of _____ and will not be returned.

I hereby hold harmless and release _____ from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

Client Name (printed) :

Date

Client Name (signature) :

Date