Infinite Skin
Aesthetic Medical Spa

1665 43rd St S
Suite 102
Fargo, ND 58103
701-282-9642

Client Intake Form

General Information

Name: _____ Today's Date: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ May we send text appt reminders? **Y** **N**

Email: _____

Date of Birth: _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____ Phone Number: _____

How did you hear about us? _____

If referred from a client please list their name so we can thank them! _____

Skin History

Concerns *(Check all that apply):*

◯ Acne/Acne Scarring	◯ Unwanted Hair	◯ Skin Laxity
◯ Brown Spots/Sun Damage	◯ Pigmented Lesions	◯ Skin Texture/Scars
◯ Rosacea	◯ Flushing of the skin	◯ Fine lines/Wrinkles
◯ Melasma	◯ Crow's Feet	◯ Dry Skin
◯ Large Pores	◯ Deep Lines/Shadows	◯ Oily Skin

How long have you had any of the above concerns? _____

Do you feel these conditions are worsening? **Y** **N** If Yes, explain_____

Are you currently being treated for any of the above conditions? **Y** **N**

If *yes*, please explain: _____

Are you currently taking any medications for a skin condition? **Y** **N**

◯ Accutane ◯ Retin-A ◯ Hydroquinone ◯ Antibiotic ◯ Other: _____

Has anyone in your family had skin cancer? **Y** **N**

If *yes*, please explain: _____

Have you had a reaction to lotions, creams, or oils? **Y** **N**

If *yes*, please explain: _____

Personal History

Do you Smoke? **Y** **N** If yes, how many daily? _____

Do you consume Alcohol? **Y** **N** Do you exercise regularly? **Y** **N**

Do you wear contact lenses? **Y** **N** Do you have any metal implants? **Y** **N**

Medical History

*Please check **ALL** that apply to you:*

◯ Active Infection	◯ Cancer	◯ Hepatitis A, B or C	◯ Pacemaker/Defibrillator
◯ Alcoholism	◯ Chemical Dependency	◯ Herpes	◯ Pigmentation disorder
◯ Anemia	◯ Chest Pain	◯ High Blood Pressure	◯ Polycystic ovaries (PCOS)
◯ Anorexia	◯ Chronic Fatigue	◯ Hormone Imbalance	◯ Sensitive Teeth
◯ Arthritis	◯ Connective Tissue Disorder	◯ HIV/Aids	◯ Skin Cancer/Moles
◯ Asthma	◯ Diabetes	◯ Keloid Scarring	◯ Skin Injury/Lesions
◯ Autoimmune Disease	◯ Eating Disorders	◯ Migraines	◯ Thyroid Disorders
◯ Bleeding Disorders	◯ Epilepsy or seizures	◯ Multiple Sclerosis	◯ Vision Deficits
◯ Breast Lump	◯ Fibromyalgia	◯ Neurologic Disorder	
◯ Bruising	◯ Heart Disease	◯ Neuromuscular Disorder	

Please list ANY Medications you are taking:

_____

_____

Are you taking any blood thinners? **Y** **N** Do you take Aspirin or Ibuprofen? **Y** **N**

Are you taking any supplements? (Vitamin E, Fish Oil, etc.) _____

Please list ANY allergies: _____

Are you pregnant or planning to become pregnant? **Y** **N** Are you nursing? **Y** **N**

Do you have any muscle issues (i.e. Strokes, Bell's Palsy, nerve injury)? **Y** **N**

If *yes*, please explain: _____

Please list any surgeries and dates of surgery:

_____

_____

_____

Cosmetic History

Have you ever had Botox and/or Filler treatments? **Y** **N**

Have you had a reaction to ANY cosmetic procedure? (i.e. Botox, Fillers, Lasers, Chemical Peels)

If *yes*, please explain: _____

_____

Is there ANY other information you would like your technician to be aware of?

_____

_____

_____

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand it is my responsibility to inform my technician of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes to my health between treatments.

_____ _____

Client Signature Date

Office use only

Reviewed By:

_____ _____ _____

R.N. Name R.N. Signature Date

_____ _____ _____

M.D. Name M.D. Signature Date

Office Notes: _____

_____

_____