Infinite Skin
Aesthetic Medical Spa

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Fargo, ND 58103
701-282-9642

# **NEW** Client Intake Form

**2025**

***General Information***

*Name:* _____ *Today's Date:* _____

*Address:* _____

*City, State, Zip:* _____

*Phone Number:* _____ *Date of Birth:* _____

*Email:* _____

*Emergency Contact Name:* _____ *Phone Number:* _____

*How did you hear about us?* _____
*If referred from a client please list their name so we can thank them!*

**Cancellation and Late Policy**

The most valuable thing you can give someone is your time, and we fully believe that everyone's time should be respected. We understand sometimes it is necessary to reschedule or cancel an appointment; however, we ask that 24 hours notice is given prior to cancelling. **In the event that you are unable to give us a 24 hours notice, a cancellation or "No Show" fee of $50 will be charged to your card.** If you arrive more than 10 minutes late to your scheduled appointment, we have the right to ask you to reschedule. We apologize for any inconvenience this may cause.

_____ _____
Client Signature Date

***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? _____

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**
*If yes please list:* _____

Have you or 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:* _____

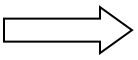
***Personal History:***

Do you smoke? **Y** **N**
Do you drink alcohol? **Y** **N**
Do you wear Contact Lenses? **Y** **N**
Do you exercise regularly? **Y** **N**
Do you have any metal implants? **Y** **N**

***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: _____



***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 | |

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** Medications you are taking:

_____

_____

Please list **ANY** allergies: _____ ☐ NONE

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:

_____

_____

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

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

_____

May we use your before and after photos **WITHOUT** identifying you in advertising? **Y** **N**

***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

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*Office use only*

**REVIEWD BY:**

_____ _____ _____
*RN Name* *RN Signature* *Date*

_____ _____ _____
*Medical Provider Name* *Medical Provider Signature* *Date*