

RETURNING CLIENT Intake Form

2025

General Information

Name: _____ Today's Date: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Date of Birth: _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

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**

Medical History

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

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

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

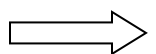
Are you taking any supplements? (Vitamin E, Fish Oil, etc.) _____

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**

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?

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

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

Reviewed By:

R.N. Name

R.N. Signature

Date

Medical Provider Name

Medical Provider Signature

Date