Infinite Skin
Aesthetic Medical Spa

1665 43rd St S
Suite 108
Fargo, ND 58103
701-282-9642

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:*

◯ 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**

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