DATE_____YOUR ESTHETICIAN IS:_____ (SPA USE)

TS Skin Care New Client Intake Form

THIS CONSULTATION FORM IS TO CORRECTLY EVALUATE YOUR SPECIAL NEEDS. THE INFORMATION IS CONFIDENTIAL AND WILL NOT BE SHARED WITH A THIRD PARTY

FIRST NAME _____LAST NAME_____M.I._____

WHAT DO YOU PREFER TO BE CALLED? _____

MAILING ADDRESS_____

CITY_____STATE_____ZIP CODE_____

EMAIL ADDRESS _____

CELL PHONE_____OTHER PHONE _____

DO YOU PREFER TO BE CONTACTED VIA TEXT OR CALL?(Circle) TEXT CALL

DATE OF BIRTH_____ AGE_____ MARITAL STATUS _____

OCCUPATION _____ SEX ☐M ☐F

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP_____

HOW DID YOU HEAR ABOUT US? Referred By: _____Relationship: _____

Internet Search☐ (What did you search for? Ex: "acne treatment," "natural skin care") _____

Print Ad/ Articles ☐ (Please Specify Publication) _____

Yelp:☐ Facebook:☐ Pandora☐ YouTube:☐ Other: (Please Specify): _____

YOUR HEALTH

WITHIN THE LAST YEAR, HAVE YOU BEEN UNDER A PHYSICIAN'S CARE? ☐Y ☐N

PRIMARY CARE PHYSICIAN _____ LAST APPOINTMENT DATE _____

WITHIN THE LAST YEAR, HAVE YOU BEEN UNDER A DERMATOLOGIST'S CARE? ☐Y ☐N

DERMATOLOGIST _____ LAST APPOINTMENT DATE _____

WITHIN THE LAST NINE MONTHS, HAVE YOU UNDERGONE ANY SURGERY? ☐Y ☐N

IF YES PLEASE SPECIFY_____

HAVE YOU HAD ANY OF THESE HEALTH PROBLEMS IN THE PAST, OR PRESENTLY?

(Please Circle)

CANCER, DIABETES, EPILEPSY, HEART PROBLEMS, HORMONE IMBALANCE, SPINAL INJURY, HYSTERECTOMY, THYROID CONDITION, SYSTEMIC DISEASE, INDIGESTION/ ACID REFLUX, ALLERGIES-IF SO, WHAT TYPE?_____

DO YOU CURRENTLY HAVE HIV/AIDS, HEPATITIS OR ANY OTHER BLOOD BORNE DISEASES?

☐Y ☐N

IF YES PLEASE SPECIFY_____

LIST ANY MEDICATIONS, OR SUPPLEMENTS, ETC. THAT YOU TAKE REGULARLY

_____

DO YOU SMOKE? ☐Y ☐N

DO YOU DRINK COFFEE REGULARLY? ☐Y ☐N

DO YOU EXERCISE REGULARLY? ☐Y ☐N

DO YOU HAVE REGULAR SLEEP PATTERNS? ☐Y ☐N

DO YOU WEAR CONTACT LENSES? ☐Y ☐N

DO YOU FOLLOW A RESTRICTED DIET? ☐Y ☐N

DO YOU EAT ANY OF THE FOLLOWING FOODS? (Please Circle)

MILK, BUTTER, CHEESE, SOY MILK/ CHEESE, PROTEIN BARS, PROTEIN POWDERS NUTS, NUT BUTTERS, SUGARS, CHOCOLATE, CANDY, PASTRIES COLAS, OTHER CARBONATED DRINKS, COOKED TOMATOES SAUCE PIZZA, FRENCH FRIES, OTHER "FAST FOODS", PORK, STEAK, YOGURT, ICE CREAM, CREAM, COFFEE CREAMER, PASTA RED SAUCE, PASTA WHITE SAUCE

YOUR SKIN

HAVE YOU EVER HAD A FACIAL BEFORE? IF SO, WHEN OR HOW LONG AGO? _____

WHAT PART OF YOUR SKIN CONCERNS YOU MOST: _____

DO YOU HAVE ANY SPECIAL SKIN PROBLEMS PERTAINING TO YOUR FACE? ☐Y ☐N

IF YES, PLEASE SPECIFY _____

WITH WHAT TEMPERATURE OF WATER DO YOU BATHE/SHOWER/CLEANSE WITH?

☐COLD ☐COOL ☐WARM ☐HOT ☐VERY HOT

WHAT SKIN CARE LINE(S) ARE YOU CURRENTLY USING? _____

WHAT PRODUCTS ARE YOU CURRENTLY USING?

☐SOAP ☐CLEANSER ☐TONER ☐MOISTURIZER ☐ MASQUE ☐EXFOLIANTS ☐EYE PRODUCTS ☐OTHERS (PLEASE SPECIFY)_____

HAVE YOU HAD THE FOLLOWING IN THE LAST MONTH? (Please Circle)

CHEMICAL PEELS, LASER RESURFACING OR MICRODERMABRASION

DO YOU USE RENOCA, RETIN A OR ADAPALEN? ☐Y ☐N

HAVE YOU EVER TAKEN ACCUTANE/ISOTRETINOIN BRANDS?

☐Y ☐N

IF YES, HOW MANY ROUNDS? _____ DATE OF LAST ROUND:_____

IF YES, MUST SIGN ATTACHED ACCUTANE/ISOTRETINOIN BRAND WAVER****

DO YOU USE ACNE MEDICATIONS? ☐Y ☐N IN THE LAST 6 MONTHS? ☐Y ☐N

IF YES, WHICH MEDICATIONS? _____

ARE YOU CURRENTLY USING ANY PRODUCTS THAT CONTAIN THE FOLLOWING INGREDIENTS?

☐GLYCOLIC ACID ☐LACTIC ACID ☐HYDROXY ACID ☐VITAMIN A DERIVATIVES (RETINOLS) ☐EXFOLIATING SCRUBS

HYDRATION

HOW MUCH PLAIN WATER DO YOU CONSUME DAILY? _____

HOW MANY CAFFEINATED BEVERAGES DO YOU CONSUME DAILY? _____

HOW MANY ALCOHOLIC BEVERAGES DO YOU CONSUME WEEKLY? _____

DO YOU EVER EXPERIENCE ANY OF THE FOLLOWING CONDITIONS WITH YOU SKIN?

☐FLAKINESS ☐TIGHTNESS ☐OBVIOUS DRYNESS ☐EXCESSIVE OILINESS

SENSITIVITY

DO YOU BURN EASILY IN MODERATE SUNLIGHT? ☐Y ☐N

DO YOU BLUSH EASILY WHEN NERVOUS? ☐Y ☐N

DO YOU HAVE A TENDENCY TOWARDS REDNESS? ☐Y ☐N

DO YOU SUFFER FROM SINUS/ RESPIRATORY PROBLEMS? ☐Y ☐N

DO YOU EXPERIENCE ANY BURNING/ ITCHING SENSATION ON YOUR FACE?

IF SO, WHERE? _____

WHAT IS YOUR PAIN THRESHOLD? ☐LOW ☐MEDIUM ☐HIGH

WHAT TYPE OF MASSAGE PRESSURE DO YOU PREFER? ☐LOW ☐MEDIUM ☐HIGH

HAVE YOU EVER EXPERIENCED CLAUSTROPHOBIA? ☐Y ☐N

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING?

☐COSMETICS ☐FRAGRANCE ☐SUNSCREEN ☐HYDROXY ACIDS ☐FOOD ☐POLLEN
☐ANIMALS ☐IODINE ☐MEDICATION ☐OTHER

(IF OTHER, PLEASE SPECIFY)_____

OIL SECRETION

DO YOU EXPERIENCE OILY SHINE DURING THE DAY? ☐Y ☐N

DO YOU EXPERIENCE BREAKOUTS? ☐Y ☐N

IF SO, WHERE AND HOW OFTEN? _____

HAIR REMOVAL

WHAT IS YOUR CURRENT FACIAL HAIR REMOVAL METHOD?

☐SHAVING ☐WAXING ☐DEPILATORY ☐TWEEZERS
☐LASER DATE OF LAST LASER TREATMENT _____

DO YOU EXPERIENCE IRRITATION/ INGROWN HAIRS? ☐Y ☐N

FOR FEMALE CLIENTS ONLY

ARE YOU TAKING ORAL CONTRACEPTION? ☐Y ☐N

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? ☐Y ☐N

ARE YOU LACTATING? ☐Y ☐N

ARE YOU ON HORMONE REPLACEMENT THERAPY? ☐Y ☐N

ARE YOU CURRENTLY HAVING OR DUE TO HAVE YOUR MENSTRUAL PERIOD? ☐Y ☐N

WHEN WAS THE DATE OF YOUR LAST MENSTRUAL PERIOD? _____

THE CLIENT ACKNOWLEDGES THAT THE INFORMATION GIVEN IS CORRECT (TO THE BEST OF THE CLIENT'S KNOWLEDGE) AND HAS NOT WITHHELD ANY INFORMATION THAT MAY BE RELEVANT TO THE TREATMENT. THE CLIENT AGREES THAT TS SKIN CARE CORP MAY IDENTIFY THE CLIENT OF TS SKIN CARE FOR MARKETING OR OTHER PURPOSES. THE CLIENT WILL NOT HOLD THE SALON/SPA OR ANY STAFF MEMBER RESPONSIBLE FOR ANY PROBLEMS WHICH MIGHT ARISE AS A RESULT OF MISINFORMATION PROVIDED IN THIS QUESTIONNAIRE.

SIGNED_____ DATE_____

_____ DATE_____

PARENT/ LEGAL GUARDIAN SIGNATURE

(Minors under the age of 18 must have a parent/legal guardian signature)

I hereby authorize and consent to any employees or esthetician at TS Skin Care to perform requested deep pore cleansing treatment services on me/my child. I hereby confirm I have disclosed any and all information needed for this service. I confirm I've had a discussion with my esthetician regarding benefits and consequences of my treatment. I understand that the treatment may involve risks or complication or injury from both known and unknown causes and I freely assume these risks. I have discussed any contraindications as well as any medications that may make me more sensitive or my heal time longer. Should I begin using any new medications during the course of treatment I will inform my esthetician. I release TS Skin Care of any and all responsibilities relating to adverse reactions due to non disclosure.

Alternative means of treatment and their risks and benefits have been explained to me. I understand that if I do not accept all risks associated with treatment I have the right to refuse treatment. I accept all responsibilities of adverse reactions due to non compliance with pre and post treatment guidelines. I release TS Skin Care staff from liability associated with my procedure for any liability that may be imposed by the laws of the state of Florida.

I agree if I have any questions, prospective adverse reaction, or concerns regarding my treatment, I will contact TS Skin Care within one week from the time of treatment to make arrangements to be evaluated. I understand that if I do not contact TS Skin Care within one week from the time of treatment TS Skin Care may not be able to accurately determine whether my question or concern is directly related to the procedure. If I choose to consult my own physician or seek any other medical attention it is at my own expense.

I certify that I have read this entire informed consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age or that if I am a minor under the age of 18, I understand that the consent of parent/legal guardian will also be required before treatment. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

PRINT NAME _____

SIGNED_____ DATE_____

_____ DATE_____

PARENT/ LEGAL GUARDIAN SIGNATURE

(Minors under the age of 18 must have a parent/legal guardian signature)

CANCELLATION/MISSED APPOINTMENT

Missed appointments have an impact on our aesthetician & staff schedules. Because we reserve longer appointment times for each client we see, a missed appointment creates a large gap in our schedule. Please be considerate of your aesthetician and provide us with **at least 24 hours** notice when rescheduling or cancelling an appointment. If failure to give notice, you will be charged a $75.00 cancellation fee.

I _____ authorize TS Skin Care to charge my credit card for $75.00, in the event that I do not cancel my appointment with a 24 hour notice or if I fail to show up for my scheduled appointment.
I also understand, that if I prepay for my treatment or have a credit from a bundle package, and do not show or fail to give 24 hours notice of my cancellation, I will lose one treatment from that package.

** Please note that reminder calls will be made a few days in advance, to remind you of your appointment, and give you an opportunity to cancel within that business day (it is your responsibility to update us on new phone numbers). This new policy is to help ensure that we will be able to schedule clients adequately and not have to waste an appointment time that someone else desired. ** We are sympathetic to emergencies and will handle them on an individual basis.

Being late for an appointment affects our aestheticians & staff, as well as our other clients. For that reason, if you are more than 25 minutes late to an appointment, we may ask that you reschedule your appointment. On the day of an appointment, if you think you will be arriving late, we ask that you call our office to inform our staff. At that time, it will be determined if your appointment will need to be rescheduled.

_____Initial

If your credit card is denied and there is failure to pay a no-show/cancellation fee, this will be treated as an unpaid balance, subject to reporting to a collection agency.

_____Initial

We reserve the right to deny appointments to any client who has not shown up or canceled an appointment without sufficient notice more than **twice.**

_____Initial

ACNE CLIENTS

All clients with acne are **required** to use our AcneCare product line after their treatment. This is to ensure proper healing of the skin and control infection.

_____Initial

When using our full system (in office treatments, home care line, and adherence to our dietary guidelines) we guarantee the results promised to you by your esthetician with 100% money back.

_____Initial

RETURN POLICY

Returns and Exchanges of Products must be made within 30 days of original purchase.

_____Initial