AESTHETICS INTAKE FORM

Patient Information

Name: Gender Pronouns: ☐ He ☐ She ☐ They ☐ Other:

Birthday: Age:

Address:

City: State: Zip:

E-mail Address:

Primary Phone: Phone Type: ☐ Home ☐ Mobile ☐ Work

Occupation: Employer: How long?

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact: Phone Number:

Concerns

What is your major complaint?

Skin goals?

Lifestyle

What is your current skincare routine? Products used?

Recent skincare treatments? Including facials, peels, laser, injectables.

AESTHETICS INTAKE FORM

Medicine & Supplements

Are you presently taking any medications? If yes, please list:

MEDICATION NAME	DOSE	REASON	STARTED?

Are you presently taking any vitamins or supplements? If yes, please list:

SUPPLEMENT NAME	DOSE	REASON	STARTED?

Do you have any allergies to medications?

Type of reaction?

AESTHETICS INTAKE FORM

Medical History

Please ☑ the box that applies to each symptom/condition listed.

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Diabetes	☐	☐	Pregnant	☐	☐	Eczema
☐	☐	Cancer	☐	☐	Nursing	☐	☐	Rosacea
☐	☐	Steroid Therapy	☐	☐	Wrinkles / Fine Lines	☐	☐	Actinic Keratosis
☐	☐	Immunosuppressive Therapy	☐	☐	Age or Sun Spots	☐	☐	Scleroderma
☐	☐	Poor Wound Healing	☐	☐	Hair Loss	☐	☐	Herpes Simplex Infection
☐	☐	Cardiac Abnormalities	☐	☐	Acne Scars	☐	☐	Bacterial or Fungal Infection
☐	☐	Blood or Platelet Disorder	☐	☐	Keloid Scars	☐	☐	Use of Isotretinoin (Accutane)
☐	☐	Collagen Vascular Disease	☐	☐	Rashes			
☐	☐	Hemorrhagic Disorder	☐	☐	Psoriasis			

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Signature: _____ Date: _____

THE FOLLOWING TREATMENTS ARE OFFERED AT ASULA, PLEASE CHECK MARK *ANY OF INTEREST TO YOU.*

☐ CHIROPRACTIC ☐ NATUROPATHY ☐ MASSAGE ☐ ACUPUNCTURE

♥ WELCOME TO OUR CLINIC ♥