Comprehensive Patient Intake

Full patient intake form with demographics, medical history, medications, and allergies for medical spa patients

Client Information

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

MM / DD / YYYY

Demographics

Gender *

- [ ] Female
- [ ] Male
- [ ] Non-Binary
- [ ] Prefer not to say

Street Address *

City *

State *

ZIP Code *

Emergency Contact Name *

Emergency Contact Phone *

Medical History

Do you have or have you ever had any of the following conditions?

- [ ] Autoimmune disorder (Lupus, Rheumatoid Arthritis, etc.)
- [ ] Bleeding or clotting disorder
- [ ] Diabetes (Type 1 or Type 2)
- [ ] Heart disease or heart condition
- [ ] High blood pressure
- [ ] Thyroid disorder
- [ ] Seizure disorder / Epilepsy
- [ ] Hepatitis B or C
- [ ] HIV / AIDS
- [ ] Cancer (current or history)
- [ ] Keloid scarring tendency
- [ ] Skin condition (Eczema, Psoriasis, Rosacea)
- [ ] Cold sores / Herpes simplex
- [ ] None of the above

If yes to any of the above, please provide details

Are you currently pregnant or nursing? *

- [ ] Yes
- [ ] No
- [ ] Unsure

Have you had any of the following treatments in the past 12 months?

- [ ] Botox / Neurotoxin injections
- [ ] Dermal fillers
- [ ] Chemical peel
- [ ] Laser treatment
- [ ] Microneedling
- [ ] Facial surgery
- [ ] None of the above

Current Medications & Allergies

List all current medications (including supplements and vitamins)

Are you currently taking blood thinners (Aspirin, Warfarin, Ibuprofen, etc.)? *

- [ ] Yes
- [ ] No

Have you taken Accutane (isotretinoin) in the past 6 months? *

- [ ] Yes
- [ ] No

List all known allergies (medications, latex, foods, etc.) *

Have you ever had an allergic reaction to local anesthesia (e.g., Lidocaine)? *

☐ Yes ☐ No

Current Skin Care

How would you describe your skin type? *

☐ Dry ☐ Oily ☐ Combination
☐ Sensitive ☐ Normal

List your current skincare products

What are your primary treatment goals? *

Consent & Signature

I certify that the information provided above is accurate and complete to the best of my knowledge. I understand that withholding or providing inaccurate information may affect my treatment plan and outcomes. I agree to notify the practice of any changes to my health status or medications.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

Date

Print name

Date *

MM / DD / YYYY