SpaBLUE
12114 N. Guinevere Dr.
Spokane, WA 99218
509.468.7747 || 509.701.3984

SpaBLUE in the city
216 N. Bernard
Spokane, WA 99201
509.867.6666

MICRONEEDLING CLIENT INTAKE FORM

Name:	Date: DOB:
Address:	Email:
	Employer:
Home Phone: Cell:	Emergency Contact:
Work Phone: ☐ I want to receive promotions and communications through email.	How did you hear about us?

MEDICATIONS

Please list any and all medications including (Topical Prescriptions) or supplements (aspirin, herbals, fish oil, etc.) you are taking:

☐ Retin-A ☐ Hydroquinone ☐ Differin ☐ Renova ☐ Blood Thinner

☐ Accutane (current or within the past 6 months?) _____

☐ Other skin care medications / topical steroids in treatment area within the past 3 months: _____

ALLERGIES

Please list any allergies:

Please list any allergy to any medication:

Are you currently pregnant or planning on becoming pregnant? ☐ Yes ☐ No Are you currently nursing? ☐ Yes ☐ No

PLACE A CHECK MARK IN EACH CONDITION(S) THAT APPLIES TO YOU:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Asthma
- ☐ Autoimmune Disease (Seleroderma)
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cardiac Abnormalities
- ☐ Collagen Vascular Disease
- ☐ Connective Tissue Disorder
- ☐ Chemical Dependency
- ☐ Chronic Fatique
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hepatitis A, B or C
- ☐ Herpes / Cold Sores
- ☐ HIV / Aids
- ☐ History of Keloid Scarring
- ☐ History of Eczema, Psorisis and Other Chronic Conditions
- ☐ History of Actinic (Solar) Keratosis
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Neuromuscular Disorder
- ☐ Pacemaker of Defibrillator
- ☐ Pigmentation Disorder
- ☐ Polycystic Ovaries
- ☐ Seizures
- ☐ Skin Lesion

SKIN CARE

What is you daily skin care regimen?

SUN HISTORY & LIFESTYLE

How often do you work outdoors? ☐ Frequently ☐ Occasionally ☐ Very Rarely

Have you or any of your family had skin cancer? ☐ Yes ☐ No If yes, please explain: _____

How often do you use a sunsreen? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

How often do you use tanning beds? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

Which of the following best describes your skin type?

☐ Very Oily Skin, Large Pores ☐ Combination Skin, Oily in T-Zone, Dry to Normal Cheeks ☐ Dry Skin ☐ Sensitive Skin ☐ Oily Skin

INTERESTS/CONCERNS:

☐ Acne
☐ Rosacea
☐ Dryness
☐ Fine Lines
☐ Wrinkles
☐ Large Pore Size
☐ Scars
☐ Discoloration
☐ Pigmentation
☐ Brown Spots
☐ Broken Capillaries / Veins
☐ Oily Skin
☐ Loss of Skin Tone
☐ Skin Treatments / Products
☐ Other Concerns? Please list below:

PREVIOUS PROCEDURES:

Which of the following have you had in the past?

☐ Microdermabrasion
☐ Chemical Peels
☐ Laser Skin Therapy (IPL/Photo)
☐ Laser Hair Removal
☐ Permanent Make-Up
☐ Electrolysis
☐ Waxing
☐ Botox / Juvederm / Radiesse / Restalyne / Collagen (Fillers)

If yes, when?

AUTHORIZATION

Patient is responsible for all charges incurred. At this time, the office will **NOT** file insurance. Payment in full is due at time of service.

I, _____ , have read and understand the above statement of payment policy, I authorize the Aesthetic Professional to administer such treatment, as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offer by the physician, physician assistant nurse practitioner, and esthetican, and I consent to care by such providers. I understand these services are voluntary and that I have the right to refuse these services.

SIGNATURE:	DATE:

***Please allow _____ hours notice in the event of appointment cancellation.**

Patient with more than _____ no-show or late appointments **will be charged a service fee of** _____ for future appointments.

I authorize this facility to release information to (please check all that apply and provide first / last name and phone numbers):

☐ Spouse: _____ ☐ Children: _____

☐ Others: _____ ☐ No one

SIGNATURE:	DATE: