URBAN SKIN SOLUTIONS™
Medspa & Weight Loss Center

CLIENT INTAKE FORM

Name: _____ Date: ____/____/____

Email:(please print)_____

☐ I want to receive promotions and communications through email.

Address: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell:_____ Work Phone: _____

Date of Birth: _____/_____/_____ Employer: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Medications
Please list any medications or supplements (aspirin, herbals, fish oil, etc.) you are taking:

_____

☐Retin-A ☐Differin ☐hydroquinone ☐ Renova ☐Other skin care medications/topical agents
☐Accutane (current or within the past 6 months?)

Allergies
Please list any medication allergies: _____

WOMEN ONlY
First day of last menstruation?_____
Are you currently pregnant or planning on becoming pregnant? ☐yes ☐no

Please Check all that apply to you

☐Alcoholism	☐ Cancer	☐ HIV/Aids	☐Bleeding Disorder
☐Anorexia	☐ Connective tissue disorder	☐ Migraines	☐ Herpes/ Cold Sores
☐Anemia	☐ Chemical Dependency	☐ Epilepsy	☐ Skin Lesion
☐ Asthma	☐ Fibromyalgia	☐ Neuromuscular	☐ History of Keloid Scarring

SKIN CARE

What is your daily skin care regimen?

_____

_____

SUN HISTORY & LIFESTYLE

How often do you work outdoors? ☐ Frequently ☐ Occasionally ☐ Very Rarely
Have you or any member of your family had skin cancer? ☐ Yes ☐ No
How often do you use a sunscreen? ☐ Frequently ☐ Occasionally ☐ Very Rarely
How often do you use tanning beds? ☐ Frequently ☐ Occasionally ☐ Very Rarely
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

CONCERNS / INTERESTS

Unwanted hair Area:_____
☐ Acne/Acne Scars
☐ Rosacea
☐ Dryness
☐ Fine lines/Wrinkles
☐ Skin Tightening
☐ Large pore size
☐ Other concerns?

☐ Weight loss/body contouring
☐ Pigmentation/Uneven skin tone
☐ Brown spots/sun damage
☐ Broken capillaries/veins
☐ Stretch marks
☐ ingrown hairs/ razor bumps
☐ longer fuller / eye lashes

Please list:_____

Are you wearing contact lenses? ☐ Yes ☐ No

Weight Loss (Only fill if you have an appointment for weight loss consultation)

1. To the best of your knowledge, how would you rate your health? ☐ excellent ☐ good ☐ fair ☐ poor

2. Present Weight (lbs): Height (inches): Desired Weight:

3. In what time frame would you like to be at your desired weight?

4. What is the main reason for your decision to lose weight?

5.Does your family support your efforts to lose weight? ☐ yes ☐ no

6. Are they overweight or obese? ☐ yes ☐ no

7. Do you suffer from any of these health conditions?

High Blood Pressure	☐ yes ☐ no	Hight Cholesterol	☐ yes ☐ no	Diabetes	☐ yes ☐ no
COPD	☐ yes ☐ no	Asthma	☐ yes ☐ no	Heart disease	☐ yes ☐ no
Arthritis	☐ yes ☐ no	Breast Cancer	☐ yes ☐ no	PCOS	☐ yes ☐ no

8. List any medical problems that other doctors have diagnosed?

9. Surgeries (year and reason)

10. Other Hospitalizations:

11. List your prescribed drugs and over the counter drugs, such as vitamins and supplements:

12. Allergies to medications:

HEALTH HABITS AND LIFESTYLE

1. Exercise (please check what applies to you)
   ☐sedentary (little or no exercise) ☐Lightly active (light exercise 1-3 times/week)
   ☐Moderately active (moderate exercise/sports 3-5 times/week)
   ☐Very active (hard exercise/sports 6-7 times/week) ☐Extra active (very hard exercise/sports & physical job or 2x training)

2. Diet Are you dieting? ☐yes ☐ no
   If yes, are you on a physician prescribed medical diet? ☐yes ☐ no
   Number of meals you eat in an average day?
   How often do you eat out? ☐ never ☐ Less Often ☐ Frequently
   What restaurants do you frequently eat out at?
   How often do you eat "fast foods?" ☐ never ☐Less Often ☐Frequently
   What time of day and on what day do you shop for groceries?
   Rank fat intake ☐ Hi ☐ Med ☐ Low

3. Caffeine ☐ none ☐ coffee ☐ tea ☐ cola Number of cups/cans per day?_____

4. Alcohol Do you drink alcohol? ☐yes ☐no If yes, how many per week?_____

5. Tobacco Do you use tobacco? ☐yes ☐no
   What kind of tobacco ☐ cigarette ☐ chew ☐ pipe ☐ cigars How much per day?_____
   Number of years smoking? _____ If you did smoke,but quit, what year did you quit?_____

6. Drugs Do you currently use recreational or street drugs? ☐yes ☐ no

DIETARY HISTORY

1.Record all weight loss attempts starting with your first diet through your most recent attempt.

2. If you have tried weight-loss medications also, include the type of diet plan you followed(e.g. low fat, 1200 calorie,etc.)while receiving the medication.

3. **MENTAL HEALTH** 1. Is stress a major problem for you? ☐yes ☐ no
   2. Do you feel Depressed? ☐yes ☐ no
   3. Do you have problems with eating or your appetite? ☐yes ☐ no

Urban Skin Solutions, or any of their employees or agents, is not liable for damages resulting from conditions. facts, or circumstances not provided in response to the above questions.

_____ _____
Client Signature Date

_____ _____
Esthetician Signature Date

_____ _____
N.P/P.A Signature Date