



Client Intake

Today's Date ____/____/____

First Name: _____ Last Name: _____

Date of Birth ____/____/____ Email: _____

Ethnic Background, please include all nationalities: _____

Address _____

Apt. # _____ City: _____ State _____ Zip _____

Home Phone (____) _____ Cell (____) _____

Occupation: _____

If we call you at home, do you want confidentiality? No Yes

Emergency Contact, Name _____ Phone (____) _____ Relationship _____

Who may we thank for referring you? _____

Procedure(s) desired:

Brows

Lips

Follow-ups

List all medications you are presently taking

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you took in the last six months that you are no longer taking:

Name of drug	Mg. or mcg.	How many ea. day	Why it was prescribed to you?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Practitioner Signature _____ Date ____/____/____

GENERAL MEDICAL Client Name: _____

Do you have? (Circle all that apply)

- **Fever Blisters/Cold Sores (Ever, even one time)**
- Glaucoma or other eye disease/disorder
- Grave's Disease
- Heart Disease
- Shingles History/ Recent Shingles Shot
- Mitral Valve Prolapse
- Valve Implants
- Pacemaker
- Stents
- Diabetes requiring insulin
- Problems with healing
- Keloids
- Seizures
- Dermatological Disorder
If so, what? _____
Active or in Flare-ups? _____
- Hemophilia or Clotting Disorder
- Autoimmune Disorder
- Pre-existing nerve damage
- Tattoos: Colors you are sun sensitive to:

- Trichotillomania (pulling of hair, brows, lashes)
- Alopecia Totalis or Areata
- Allergies
List: _____

Are you? (Circle all that apply)

- Pregnant
- Planning cosmetic surgery
If so, what & when? _____
- Currently under the care of a physician
Describe: _____

Do you practice outdoor activities? Circle all that apply

Tennis	Swimming
Golf	Skiing
Gardening	Walking
Boating	Other

Do you use? (Circle all that apply)

- Accutane (currently or within the past year)
- Antibiotics prior to dental procedures
- Steroids
- Retin-A, Glycolic Acid, Vitamin C or other Exfoliants
- Tanning Beds
- Eyebrow Tinting
- Eyelash Tinting
- Latisse
- Botox When _____
- Chemical Peels When _____
- Chemotherapy or Prophylactic dose of Chemotherapy
- Blood Thinners

Have you had? (Circle all that apply)

- Fever Blisters/Cold Sores (Ever, even one time)
- Eye Infections (Are you prone to them)
- Vision Correction Procedure (Lasik, RK) within the past 3 months
- Heart Attack - When? _____
- Joint Replacement, Organ Transplant
- Eye Trauma
- Seizures
- Fainting Spells
- Hepatitis - What Type: _____
- Hepatitis Test - When? _____ Fat Transfer Injections - If yes, where? _____
- Gore-Tex Implants - If yes, where? _____
- Aesthetic or Cosmetic Procedures If yes, where? _____
- Laser Treatments: What type & why? _____

Physician's Name: _____
Address: _____
Phone: _____
Specialty: _____

Client Signature _____ Date ____/____/____