Apothecary Skin Therapy

ORGANIC AND CLINICAL ESTHETICS

Confidential Client Intake Form

Welcome! I would like to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your session, please let me know.

Name _____ Preferred Phone Number _____

Street Address _____

City, State, ZIP _____

Birthday _____ Email _____

Referred by: _____

Health History

These questions are relevant to your skin health and may be contraindications for treatment.
Please answer thoroughly & also list details / adverse reactions, if applicable.

Yes	No		*List details / adverse reactions here, if applicable:*
❍	❍	Do you have any metal implants, including plates, screws or pins?	
❍	❍	Do you wear contacts or glasses?	
❍	❍	Do you have any metal piercings?	
❍	❍	Do you use a pacemaker?	
❍	❍	Do you have any heart problems?	
❍	❍	Do you have high blood pressure?	
❍	❍	Do you have braces, metal fillings, or other dental implants?	
❍	❍	Do you currently have a cold or flu?	
❍	❍	Do you have an autoimmune disorder?	
❍	❍	Do you have connective tissue disease?	
❍	❍	Have you had any previous facial treatments?	
❍	❍	Do you use Retin-A®, Accutane® or any other prescribed topical Vitamin A derivative?	
❍	❍	Have you ever had Botox®, Juvederm®, or any other injectable?	
❍	❍	Are you pregnant or nursing?	

Please turn over & fill out back

Please list any allergies you have:

_____

Please list any current medications you are taking (including oral and topical prescriptions, over-the-counter herbs, vitamins and supplements):

_____

_____

Have you ever had any of these conditions? Check all that apply.

- ❑ Acne
- ❑ Rosacea
- ❑ Bell's Palsy
- ❑ Cold Sores
- ❑ Diabetes
- ❑ Embolism
- ❑ Epilepsy
- ❑ Light Sensitivity
- ❑ Melanoma
- ❑ Migraines
- ❑ Open Wounds
- ❑ Phlebitis
- ❑ Recent Scar Tissue
- ❑ Sensitive Skin
- ❑ Psoriasis
- ❑ Skin Inflammations/ Disorders
- ❑ Stroke/TIA
- ❑ Thrombosis
- ❑ Thyroid conditions

Any other health condition not listed:

_____

What are your skin care concerns? Check all that apply.

- ❑ Wrinkles/Fine Lines
- ❑ Blackheads
- ❑ Dull/Dry Skin
- ❑ Flaky Skin
- ❑ Oily Skin
- ❑ Sensitive Skin
- ❑ Redness/Rosacea
- ❑ Hyperpigmentation/ Sun Spots
- ❑ Acne
- ❑ Loss of Elasticity
- ❑ Broken Capillaries

Any other skin condition not listed:

_____

_____

What is your skin care goal for today's treatment?

_____

_____

Please read the following statements and sign below:

1. I understand that skin therapy is not a substitution of medical examination, diagnosis, and treatment.
2. Being that facial treatments should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully and will continue to update the therapist on any current condition.
3. I hereby acknowledge that I have read and received a copy of the "Appointment Policies" and will adhere to them. Cancellations within 24 hours will be charged the full price of the scheduled service.

Signature _____ Date _____

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Informed Consent for Microneedling

I, _____, understand the following in regards to my treatment that I will be receiving today.

1. No guarantee can be given to me as to the condition of my skin or degree of improvement expected following treatment.
2. I understand that multiple treatments and the use of the recommended home skin care maintenance are required to achieve optimal results.
3. I am not pregnant or lactating.
4. If outdoors I will apply sunscreen that is at least SPF 35 or higher 30 minutes prior to sun exposure.
5. In rare cases allergies or sensitivities have been reported to products during treatments.
6. The following are all contraindications that will prevent me from receiving treatment

- Infected skin disorder, open cuts, wounds, or abrasions
- Cardiovascular disease, must receive written permission from PCP
- A Pacemaker
- Anxiety issues
- Epileptic
- Pregnant
- Sunburned or irritated skin
- Untreated sinusitis
- Numb areas without sensitivity
- Diabetes

7. I understand the following side effects could occur:

- Fever blisters could develop
- Little white dots can appear following treatment, typically these are retention cysts and can be treated by firmly wiping them away and applying a tiny amount of antibiotic
- If skin becomes painful or redness persists you may have an infection and contact your service provider immediately

_____ _____

Patient Signature Date

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Semi-Permanent Makeup/Microblading
Postcare Information

- Keep a very thin layer of Vaseline on the treated areas. **Please note that too much Vaseline may drown the pigment and too little may cause scabbing that may result in pulling of the pigment around the treated area.**
- Avoid contact with location for up to 3 hours after procedure.
- Treated areas may be iced when inflamed.
- Keep treated area free of makeup, lotions and/or astringents for up to 10 days.
- You may gently wash with clean hands, warm water, and mild antibacterial soap. Do not rub hard. Pat gently when drying.
- Use clean pillow case and avoid heavy sweating and hot showers for the first 10 days.
- Stay out of direct sunlight and tanning beds until the procedure is fully healed.
- Do not soak brows with water.
- Avoid facials, chemical treatments, Botox, facial scrubs, ect. for 3-4 weeks.
- Consult a physician if you have any signs of infection, green or yellow discharge, and/or fever.
- **Please do not pick scabbing. This will result in loss of pigment and compromise desired results.**

Long Term After-care Instructions

- Inform physician of any tattoo before any laser procedures or MRIs.
- Always use sunscreen on tattooed location to prevent fading. Extreme sun exposure will fade pigment.
- The use of chemical peels may result in fading pigment.