Esthetician Client Intake & Consent Form

Please complete this form before your first treatment. All information is confidential and used to provide safe, appropriate services.

1. Client Information

Full Name: _____

Preferred Name: _____

Date of Birth: _____ **Pronouns:** _____

Phone: _____

Email: _____

Address: _____

Emergency Contact: _____

Relationship: _____ **Phone:** _____

How did you hear about us?

☐ Referral ☐ Website ☐ Social media ☐ Search engine ☐ Advertisement ☐ Other: _____

2. Health History

Please check any that apply:

☐ Pregnant or breastfeeding
☐ Diabetes
☐ Epilepsy or seizures
☐ Asthma
☐ High or low blood pressure
☐ Heart condition
☐ Blood-thinning disorder
☐ Autoimmune condition
☐ Immune-system disorder
☐ Skin disease or infection
☐ Cold sores/herpes simplex
☐ Rosacea
☐ Eczema, psoriasis, or dermatitis
☐ Keloid scarring
☐ Allergies or sensitivities
☐ Recent surgery or medical procedure
☐ Cancer or cancer treatment
☐ Other medical condition: _____

Please provide additional details, if applicable:

Are you currently under the care of a physician or medical provider for any condition?

☐ No ☐ Yes — Please explain: _____

3. Medications and Allergies

Current medications, supplements, or topical products:

_____

_____

Known allergies or sensitivities:

☐ No known allergies
☐ Fragrance
☐ Latex
☐ Adhesives
☐ Latex
☐ Retinoids
☐ Aspirin/salicylic acid
☐ Other: _____

Have you ever experienced an allergic reaction to a cosmetic or skincare product?

☐ No ☐ Yes — Please describe: _____

4. Skin History

Primary skin concerns:

☐ Acne
☐ Dehydration
☐ Dryness
☐ Oiliness
☐ Sensitivity
☐ Redness
☐ Hyperpigmentation
☐ Uneven texture
☐ Fine lines/wrinkles
☐ Sun damage
☐ Ingrown hairs
☐ Other: _____

How would you describe your skin?

☐ Dry ☐ Normal ☐ Combination ☐ Oily ☐ Sensitive ☐ Unsure

Current skincare routine and products:

Cleanser: _____

Toner/Essence: _____

Serum/Treatment: _____

Moisturizer: _____

Sunscreen: _____
Other products: _____
Have you used any of the following within the past 7 days?
☐ Retinol or prescription retinoids
☐ AHAs/BHAs or exfoliating acids
☐ Benzoyl peroxide
☐ Scrubs or exfoliating devices
☐ At-home chemical peels
☐ Acne medication
☐ Self-tanner
☐ Waxing, threading, or depilatory products
☐ None of the above
Date of most recent facial, peel, waxing, laser, microneedling, injectables, or other cosmetic treatment:

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5. Lifestyle and Sun Exposure

How often do you use sunscreen?
☐ Daily ☐ Occasionally ☐ Rarely ☐ Never
Recent sun exposure, sunburn, or tanning-bed use:
☐ No ☐ Yes — Date/details: _____
Do you smoke or use nicotine products?
☐ No ☐ Yes
Typical water intake: _____
Other relevant lifestyle information:

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6. Treatment Goals

What would you like to address during your appointment?

What are your treatment goals or desired results?

Are there any products, ingredients, or techniques you do not want used?

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7. Contraindications and Safety Confirmation

Please notify your esthetician before treatment if you have:

- Open wounds, active infection, severe irritation, or a contagious skin condition
- A recent sunburn
- Recent cosmetic injections, laser treatment, surgery, or strong exfoliation
- Any new medication or medical diagnosis

- An active cold sore or unexplained rash
- Known allergies or sensitivities

Your esthetician may modify, postpone, or decline a service when necessary for your safety.

8. Consent to Treatment

I understand that esthetic services may cause temporary redness, sensitivity, dryness, irritation, swelling, breakouts, bruising, or other reactions. I understand that results vary and cannot be guaranteed.

I agree to provide complete and accurate health information and to inform my esthetician of any changes before future treatments. I understand that failure to disclose relevant information may increase the risk of an adverse reaction.

I have had the opportunity to ask questions and voluntarily consent to the recommended esthetic services.

Client Signature: _____

Date: _____

Parent/Guardian Signature, if applicable: _____

Relationship: _____ **Date:** _____

9. Photo Consent

Please select one:

☐ I consent to before-and-after photographs for treatment documentation only.

☐ I consent to photographs being used anonymously for educational or marketing purposes.

☐ I do not consent to photographs being taken or used.

Client Initials: _____

10. Privacy and Communication Consent

I authorize the establishment to contact me regarding appointments, aftercare, scheduling, and relevant services.

Preferred contact method:

☐ Phone ☐ Email ☐ Text message

I understand that my personal and health information will be handled confidentially, subject to applicable privacy laws and business policies.

Client Signature: _____

Date: _____

For Esthetician Use Only

Date: _____ **Esthetician:** _____

Skin analysis:

Treatment performed/recommended:

Products/ingredients used:

Patch test performed? ☐ No ☐ Yes — Result: _____
Client reaction during treatment:

Aftercare instructions provided:

Next recommended appointment: _____
Esthetician Signature: _____
Customize this form to your services, products, business policies, and local privacy and professional requirements. Consider having it reviewed by an attorney or appropriate regulatory professional before use.