Confidential Client Intake Form

LORÉN
SKIN & BODY

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply:

- ☐ Acne
- ☐ Diabetes
- ☐ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hypo Pigmentation
- ☐ Lupus
- ☐ Pregnant
- ☐ Seborrhea
- ☐ Hype/Hypo Thyroid
- ☐ Arthritis
- ☐ Eczema
- ☐ Heart Condition
- ☐ HIV
- ☐ Insomia
- ☐ Sinus Infection
- ☐ Psoriasis
- ☐ Shingles
- ☐ Warts
- ☐ Depression
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Hyper Pigmentation
- ☐ Low Blood Pressure
- ☐ Surgery:
- ☐ Rashes
- ☐ Skin Cancer
- ☐ Other: _____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please explain:

Have you had any facial or dermatology services in the past 30 days? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Skin Care History

Check the products that you currently use (please select all that apply):

- ☐ Body Lotion
- ☐ Cleansing Cream
- ☐ Eye Cream
- ☐ Facial Scrub
- ☐ Night Cream
- ☐ Body Soap
- ☐ Day Cream
- ☐ Exfoliants
- ☐ Hand Cream
- ☐ Skin Toner/Astringent
- ☐ Body Scrub
- ☐ Eye Makeup Remover
- ☐ Facial Soap
- ☐ Neck Cream
- ☐ Other: _____

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache
☐ Inflammation ☐ Insomia ☐ Muscle Cramps ☐ Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐ Acne/Breakouts
☐ Blackheads/Whiteheads
☐ Broken Capillaries
☐ Clogged Pores
☐ Dark Spots
☐ Dryness
☐ Excessive Oil/Shine
☐ Redness
☐ Rosacea
☐ Scarring
☐ Sun Damage
☐ Uneven Skin Tone
☐ Unwanted Hair
☐ Wrinkles/Fine Lines
☐ Other: _____

Have you been under the care of a dermatologist within the past year? Yes ☐ No ☐

If yes, please explain:

Have you used Retin-A, Renova, AHAs or Retinal/Vitamin A products in the last three months? Yes ☐ No ☐

If yes, please explain:

Have you received Botox, Restylane, or Collagen injections in the last 6 months? Yes ☐ No ☐

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

_____ _____ _____

Name Printed Signature Date

Client Consent Form & Liability Waiver

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I hereby consent to and authorize _____ to perform the following procedure:

_____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment have been explained to me.

I understand and acknowledge that there are risks involved with the treatment I will be receiving. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understood the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Esthetician Name	Signature	Date

Photograph and Video Release Form

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I, _____ hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, video, and/or audio is taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social networking sites, and other print or digital communications without payment or any other consideration. This authorization extends to all languages, media, formats, and markets now known or later discovered. I waive the right to inspect or approve the finished product wherein my likeness appears, including a written or electronic copy. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I hereby hold harmless and release _____ from all liability, petitions, and causes of action which I, my heirs, representatives, executors, or any other persons may make while acting on my behalf or on behalf of my estate.

Picture/Video/Audio Description:	Date taken:
_____	_____
_____	_____
_____	_____
_____	_____

_____ Name Printed

_____ Signature

_____ Date

Covid-19 Liability Release Form

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Due to COVID-19, we are taking extra precautions with each client and have improved our sanitation and disinfecting practices. Please complete the following and sign below.

☐ I confirm that I, nor anyone in my household have any of the following symptoms of COVID-19 listed below, nor have had any of the following symptoms in the past 14 days:

☐ Fever	☐ Body aches
☐ Chills	☐ Headache
☐ Cough	☐ New loss of taste or smell
☐ Shortness of breath	☐ Sore throat
☐ Difficulty breathing	☐ Congestion or runny nose
☐ Fatigue	☐ Nausea or vomiting
☐ Muscle aches	☐ Diarrhea

☐ To the best of my knowledge, neither I nor anyone in my household has been in contact with anyone who has tested positive for COVID-19. _____(initial)

☐ I verify that neither I nor anyone in my household has traveled outside of _____ in the past 14 days._____(initial)

☐ I understand that the CDC recommends social distancing of at least 6 feet, and this is not possible with the service I am receiving today. _____(initial)

By signing below I knowingly and willingly consent to release any and all liability for the unintentional exposure or harm due to COVID-19.

_____	_____	_____
Name Printed	Signature	Date

Client Treatment Plan

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Client Name	Treatment received

I recommend the following professional treatments for you to help achieve the results you desire

Treatment Type				
Schedule every	☐ Days	☐ Weeks for a total of		Treatments
Treatment Type				
Schedule every	☐ Days	☐ Weeks for a total of		Treatments

Home care:

Cleanser:	How Often:
Exfoliant:	How Often:
Serum:	How Often:
Moisturizer:	How Often:
SPF	How Often:
Repair Tx	How Often:
Mask:	How Often:
Spot Tx	How Often:
Other:	How Often:

If you have any questions about your treatment plan or when and how to use your home care products, please contact me. Your treatment plan may change depending on the rate of progress and changes in your skin.

☐ I understand that to achieve maximum benefits and maintain the results from my professional treatments, it is essential that I use the home care products as outlined above. _____ (initial)

☐ I commit to my success by pledging to wear sunscreen daily. _____ (initial)

_____	_____	_____
Printed Name	Signature	Date
_____	_____	_____
Esthetician Name	Signature	Date

Client Treatment Record

(For Professional Use)

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Client Full Name

Client Phone Number

What type of skin do they have? ☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Sensitivities

Date	Treatment Details	Notes	Esthetician	Price

Skin Type Guide

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Skin Type	Major Identifiers	Cleanser Recommendations	Ingredients to Avoid
Normal	• Pores barely visible • Even skin tone • Minimal skin sensitivities and blemishes	Micellar water, gel, oil, or cream cleaners with hyaluronic acid to keep the complexion youthful and glowing	
Dry	• Small pores • Dull, rough skin • Prone to redness and flaking	Micellar water/cream cleaners with humectants such as hyaluronic acid and glycerin	• Alcohol • Retinol • Salicylic Acid • Benzoyl Peroxide
Oily	• Larger pores • Shiny/greasy skin • May have blemishes/blackheads	Gel/foam cleaners that contain salicylic/glycolic acid	• Mineral Oil • Petrolatum • Alcohol
Combination	• Medium sized pores in T-zone • Oily in T-zone • May have blemishes/blackheads	Gel/foam cleaners that contain glycolic/lactic acid	• Alcohol • Retinol • Salicylic Acid • Benzoyl Peroxide • Mineral Oil • Petrolatum
Sensitive	• Fine/Larger pores • Redness, itching and dry skin • Prone to irritation	Cream cleaners/micellar water that are hypoallergenic and sulfate-free	• Perfumes • Fragrances • Preservatives

Skin Care History

Please list any skin care products that you currently use:

Have you used any AHA products in the last 72 hours?	☐ Yes	☐ No
Are you using Retin-A, Renova, or Accutane?	☐ Yes	☐ No
Are you using any other skin thinning products and/or drugs?	☐ Yes	☐ No
Are you exposed to the sun on a daily basis?	☐ Yes	☐ No
Do you currently have a sunburn?	☐ Yes	☐ No
Do you plan on spending more time in the sun soon?	☐ Yes	☐ No
Have you recently used a tanning bed?	☐ Yes	☐ No
Have you recently had a chemical or glycolic peel?	☐ Yes	☐ No
Have you waxed before?	☐ Yes	☐ No

If yes, when?

If yes, did you have any adverse reactions? Yes ☐ No ☐

If yes, please explain:

Do you have any abrasions, moles, or skin irritations in the areas being waxed today? Yes ☐ No ☐

If yes, please explain:

(Female clients) When is your next menstrual cycle due to begin?_____

(For your own comfort, we recommend avoiding hair removal from two days before to two days after your cycle.)

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
Esthetician Name Printed	Signature	Date

Client Consent Form & Liability Waiver

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I hereby consent to and authorize _____ to perform the following waxing procedure:

_____

I understand that waxing may have certain side effects which may include but are not limited to skin removal, redness, swelling, and tenderness. I have had the opportunity to ask questions regarding these side effects and other possible complications. I give permission to my esthetician to perform the waxing procedure we have discussed and I will hold them and the spa harmless from any liability that may result from this treatment.

I have read and understand the aftercare home care instructions. I understand how important it is to follow all instructions given to me for aftercare. In the event that I may have additional questions or concerns regarding my treatment and suggested aftercare, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

_____	_____	_____
Name Printed	Signature	Date
_____	_____	_____
Esthetician Name	Signature	Date

Informed Consent for Microdermabrasion

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I, _____ give my consent for microdermabrasion to be performed by

_____

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.
_____ I have voluntarily elected to receive microdermabrasion after the nature and purpose of this treatment has been explained to me.
_____ I understand that microdermabrasion can be used to diminish the appearance of fine lines and wrinkles, improve texture/tone, reduce pore size, increase hydration and moisture retention, give skin a smoother appearance and diminish the appearance of hyperpigmentation.
_____ I understand that the following conditions preclude me from having this treatment at this time and verify that none of the following conditions apply to me at this time:

- Pregnancy/Lactating
- Herpes Simplex (cold sores or fever blisters)
- Unhealthy or broken skin
- Inflammation
- Extensive sun or tanning 3 days prior and 3 days post-treatment
- Accutane in the past 6 months to 1 year
- Glycolic acid products, Retin-A or Renova in the last 4 weeks
- Waxing the area to be treated in the past 7 days
- Any other chemical peel within 8 weeks of the treatment

_____ I recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.
_____ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

- Mild to moderate discomfort or pain
- Acne or milia breakout
- Slight redness or swelling
- Itching or irritation
- Sun sensitivity
- Skin sensitivity
- Pigment changes
- Scarring
- Allergic reaction
- Bacterial infection
- Skin peeling or flaking up to 14 days after the procedure

_____ I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

_____ I have read and understood the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

_____ I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sunblock protection with a minimum of SPF 15 is mandatory.

_____ I agree to refrain from excessive sun exposure or the use of a tanning bed while I am undergoing treatment and during the 14 days following the end of the treatment.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages which might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Name Printed	Signature	Date
Esthetician Name	Signature	Date

Consent Form for Dermaplaning

LORÉN
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I, _____ give my consent for dermaplaning to be performed by

_____

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.

_____ I understand that dermaplaning is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built-up dead skin cells and vellus hair. Following treatment skin will be smoother, softer, and better able to absorb the active ingredients in treatment and home care products.

_____ I have been informed of the nature, risks, and possible complications, and consequences of dermaplaning. I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellus hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts.

_____ I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate, or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

_____ I certify that I am not taking any of the above medications or experiencing any of the above conditions. While every precaution will be taken to avoid nicks, cuts, and scratches, I understand the risks and consent to treatment today.

_____ I understand that my technician only utilizes sterilized, disposable equipment to minimize the risk of infection or contamination and that my technician has received training inappropriate sanitation and hygiene techniques prior to performing any procedures. While the risk of infection from our procedures is extremely small, the possibility of such an occurrence cannot be totally prevented. Accordingly, I understand and accept the risk and release my technician and the spa from any and all liability related to the subject procedure, except instances involving gross negligence.

_____ I grant permission to _____ to take and use: photographs and/or digital images of me for use in news releases, educational materials and/or social media platforms including but not limited to Instagram, Facebook, Twitter, Tic Toc, and Pinterest.

By signing below, I agree to the following:
I have read or have had read to me the contents of this whole form. I understand the risks and alternatives involved in this/these procedure(s) and I have had the opportunity to ask questions and all of my questions have been answered. I accept full responsibility for the decision to have dermaplaning done and understand that there is a no refund policy. I acknowledge that I have reviewed and approved the material given to me.

Name Printed	Signature	Date
Esthetician Name	Signature	Date

Skin Analysis/Evaluation Form

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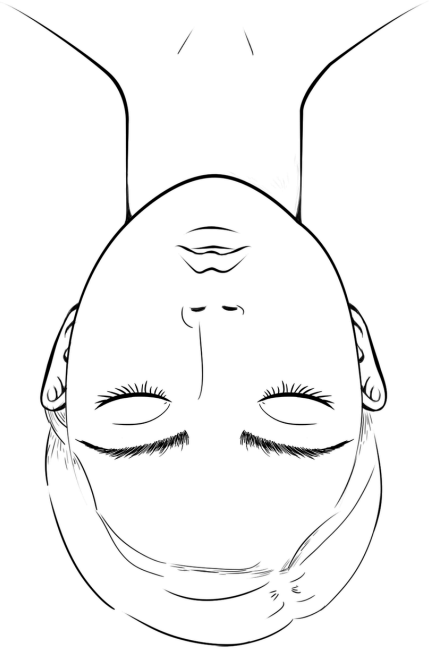
Name:		Date of Consult:
Address:	DOB:	Age:
Known Allergies:		
Current Medications:		
Previous Skin Care Treatments:		

Skin Analysis

Acne Present	☐ Yes	☐ No		
	☐ Grade I	☐ Grade II		
	☐ Grade III	☐ Grade IV		
	☐ Type I	☐ Type II	☐ Type II	
Fitzpatrick Classification	☐ Type IV	☐ Type V	☐ Type VI	
	☐ No Wrinkles	☐ Wrinkles in Motion		
Lines (Glogan Scale	☐ Wrinkles at Rest	☐ Predominantly Wrinkles		
	☐ Poor	☐ Average	☐ High	
Muscle Tone	☐ Low	☐ Average	☐ High	
Skin Blood Circulation	☐ Low	☐ Average	☐ High	
Skin Moisture Content	☐ Normal	☐ Sensitive	☐ Hypersensitive	
Skin Sensitivity	☐ Normal	☐ Dry		
Skin Type	☐ Oily	☐ Combo		

Skin Disorders/Imperfections (Marked on Diagram)

Acne	A	Open Pores	OP
Asphyxiated	As	Oily	O
Breakout Activity	Br	Papules	Pa
Broken Capillaries	BC	Photo Aging	PA
Comedones	Co	Osoriasis	Ps
Cherry Angioma	CA	Pustules	Pu
Deep Lines	DL	Moles	Mo
Dehydration	De	Sensitivity/Redness	S/R
Dilated Capillaries	D	Rasacea	R
Discoloration	Di	Scars	Sc
Eczema	E	Skin Tags	ST
Fine Lines	FL	Spider Veins	SV
Hyperpigmentation	H+	Sunburn	Su
Hypopigmentation	H-	Telangiectasia	T
Keloids	K	Thin	Th
Milia	Mi	Warts	W



Treatment Chart

Client Name:

Date:

Skin Care Professional:

Type of Treatment:

Notes/Remarks:

Treatment Information

Products Used During Treatment:

Electrical Equipment Used:

Recommended Home Skin Care Products:

	AM	PM
Cleanse		
Exfoliate		
Mask		
Tone		
Serum		
Eyecare		
Moisturizer		
Sun Care		
Special Treatment		

Future Treatment Recommendations:

Additional Advice:

Client Reaction:

Products Purchased:

Body Countoring Client Intake Form

Logo Here

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Do you have any chronic medical conditions that we should know about? Yes ☐ No ☐

If yes, please list:

Are you currently taking any medications? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Do you have type 1 or type 2 diabetes? Yes ☐ No ☐

Do you have any known kidney or liver disorders? Yes ☐ No ☐

Do you have photosensitivity to sun exposure? Yes ☐ No ☐

Do you currently have cancer? Yes ☐ No ☐

If yes, are you currently on chemotherapy? Yes ☐ No ☐

Have you had cancer in the past 12 months? Yes ☐ No ☐

Do you have any thyroid problems? Yes ☐ No ☐

Do you have high blood pressure? Yes ☐ No ☐

Do you have any cardiovascular conditions? Yes ☐ No ☐

Do you have any medical devices implanted including, but not limited to, hearing aids, a pacemaker, or hormonal pellets? Yes ☐ No ☐

If yes, please list:

What concerns would you like addressed today?

Do you want to lose body fat? Yes ☐ No ☐

If yes, from what area:

Do you want to tighten skin on your body? Yes ☐ No ☐

If yes, from what area:

Do you want to reduce cellulite? Yes ☐ No ☐

If yes, from what area:

Please list your regular exercise habits:

Please describe your current dietary habits:

How many ounces of water do you drink daily?

(Female clients) Are you currently pregnant or nursing? Yes ☐ No ☐

When was the first day of your last menstrual cycle?

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date

Informed Consent For Body Contouring

Logo Here

I, _____ give my consent for body contouring to be performed by

_____

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.
_____ I have voluntarily elected to receive body contouring after the nature and purpose of this treatment have been explained to me.
_____ I understand that body contouring can be used to reduce fat deposits but is not intended to be a weight loss solution.
_____ I understand that the following conditions preclude me from having this treatment at this time and verify that none of the following conditions apply to me at this time:

- Cardiac issues
- Cancer
- Infected, inflamed, or swollen skin
- Metallic implant (pacemaker)
- Pregnant/Lactating

_____ I recognize there are no guaranteed results.
_____ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

- Redness
- Swelling
- Irritation
- Skin reaction
- Increased heart rate

_____ I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.
_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages which might occur to me while I am undergoing this procedure. I do not hold the technician responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Name Printed	Signature	Date

Body Contouring FAQs

Logo Here

What is body contouring?
Body contouring includes surgical and nonsurgical fat reduction procedures. These procedures reduce or remove stubborn pockets of fat to contour and shape different areas of the body.

What is non-surgical body contouring?
Nonsurgical body contouring is also known as nonsurgical fat reduction. There are many types of non-surgical fat reduction procedures, but most are based on one of the following four principles:

1. Controlled cooling: using freezing temperatures to target and destroy fat cells
2. Laser lipolysis: using controlled heating and laser energy to target fat cells
3. Radiofrequency lipolysis: using controlled heating and ultrasound technology to target fat cells
4. Injection lipolysis: using injectable deoxycholic acid to target fat cells

Who is the best candidate for body contouring?
The best candidate for body contouring is someone who is close to their desired weight and wants to eliminate stubborn pockets of fat that are resistant to diet and exercise.

What is CoolSculpting?
CoolSculpting is an FDA-approved treatment that is non-invasive and uses cold temperatures to target and destroy fat cells in various areas of the body. The freezing temperature kills off fat cells, which are eventually flushed out of your body through the lymphatic system.

What is the “downtime” of these procedures?
Most nonsurgical body contouring procedures are minimally invasive to noninvasive. Generally, you can resume daily activities immediately after the treatment.

How long does a treatment take?
One treatment area takes 30-60 minutes. How many treatments are required? Multiple treatments are usually required to deliver satisfactory results.