GRACE+CLAY
ESTHETICS by JOANNE SMITH

Dermaplane Intake Form

Name:_____ Birth Date:_____
Address: _____
City:_____ State:_____ Zip:_____
Cell Phone:_____ Work Phone:_____
E-Mail Address:_____
Emergency Contact: (Name & Phone)_____
Primary Physician: _____
Do we have permission to contact you by phone or leave messages: _____Yes _____No
Preferred method of contact: _____ Phone _____Text _____E-Mail
Do we have permission to show your photos for educational purposes? _____Yes _____No

WHAT CONCERNS YOU MOST about the overall appearance of your skin? (check all that apply)
___Acne___Blackheads___Bumps on back of arms___Dehydrated Skin___Facial Veins
___Large Pores___Oily Skin___Rosacea___Under Eye Puffiness/Dark Circles ___Acne Scarring
___ Body Acne ___Cellulite___Dull Complexion ___Fine Lines/Wrinkles ___Loss of Lashes/Brows
___Redness ___Age Spots___Broken Blood Vessels ___Cysts/Nodules___Excessive Facial Hair
___Frequent Breakouts ___Melasma/Brown Spots/Patches ___Rough/Uneven Skin Texture
___Sun Damage ___Sagging Skin Other:_____
_____

How would you describe your skin? ___Oily ___Dry ___Combination ___Sensitive
How would you describe your stress level? ____Little ____Moderate ____High ____Severe
Do you feel your stress level may be affecting the health of your skin? _____Yes _____No
Are you in good health overall? _____Yes _____No Concerns:_____

Are you currently under the care of a physician? ___Yes ___No Explain:_____
_____

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Do you have any allergies to foods or medications? ___Yes ___No If yes, Please list:

_____

_____

Are you currently on any medications either topical or oral? ___Yes ___No If yes, please list:

_____

_____

How do you heal after an acne breakout, cut or scratch? ____ No scar ____ Red ____ Brown (PIH)
Do you smoke? ___Yes ___No
Are you prone to cold sores? ___Yes ___No If yes, date of last cold sore? _____
Do you have an allergy to Latex? ___Yes ___No
Do you tan in the sun or in tanning beds/booths? ___Yes ___No

Please check the skincare products you are currently using:
___Cleanser ___Toner ___Serum ____AHA, BHA, VitA ___Scrub ___Mask ___Eye Cream
___Moisturizer ___Sunscreen ___Self Tanner ___Concealer ___Makeup
Other_____

Knowing that home care is a big part of achieving beautiful skin, would you like to chat about how to maintain today's results at the end of your facial?

_____ Yes, give me the scoop on how to look and feel beautiful _____ No, just here to relax

Anything else we should know:_____
_____

The answers I have provided are true and correct to the best of my knowledge.

_____ _____

Client Signature / Date Provider Signature / Date

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Informed Consent

I, _____ give my consent for the following procedure:

Dermaplaning to be performed by _____.

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 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.

_____ _____ _____

Print Name Signature Date

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Please read carefully and initial the following:

_____ I understand that GRACE+CLAY services including facials and body treatments are cosmetic in nature and given for the sole purpose of skin cleansing, body and mind relaxation and rejuvenation.

_____ I understand that it is imperative to tell my Esthetician about any oral or topical medications prior to any facial, waxing, or body treatment services.

_____ I understand that GRACE+CLAY does not diagnose illness, disease, or any other physical or mental disorder. I accept full responsibility and do not hold GRACE+CLAY liable for loss, damage or injury.

_____ I understand that results vary and are not guaranteed.

_____ I confirm that to the best of my knowledge that the answers given on client consultation form are correct and that I have not withheld any information that may be relevant to my treatment.

_____ I understand there are risks associated with skincare treatments. Such as: redness, sensitivity, flaking or peeling, inflammation. Any additional concerns I will discuss with my practitioner.

*Please note any additional information that may be of importance to your Licensed Esthetician regarding the spa treatment you will be receiving here: _____
_____

_____ I understand that GRACE+CLAY has a strict 24-hour cancellation policy. I understand I must provide at least 24 hours advance notice for the cancellation of an appointment. Failure to provide 24-hour notice will result in a charge of 50% of cancelled service. **NO-SHOWS WILL BE REQUIRED TO PAY MISSED SERVICE IN FULL. AND PRE-PAYMENT IN FULL IS REQUIRED TO BOOK NEXT APPOINTMENT.**

Signed by Client_____ Date _____