Facial-Waxing-Dermaplaning-Body Scrub Intake Form

Name:_____ Date of Birth:____/_____/_____

Address:_____

City:_____ State:_____ ZIP Code:_____

Phone Number:_____ Email:_____

In case of emergency, contact:_____ Phone #:_____ Relation:_____

Can we confirm your future appointments via text message to the mobile number above: Yes or No

Skin Type: Please Circle all that apply
Normal Sensitive Rosacea Combination Oily Dry Mature Acne Breakouts

What skin conditions would you like to improve: Please Circle all that apply: Hair Removal
Acne/Acne Scarring Pustules (Inflamed) Enlarged Pores Blackheads/Whiteheads

Age Spots Visible Capillaries Sun Damage Fine Lines/Wrinkles Hyperpigmentation

Have you ever been prescribed Accutane?
Yes No Last Date Used _____

Please circle if using any of the following: Hydroquinone Glycolic/Alpha Hydroxy Acid

Retinoid (Vitamin A derivatives:Retin-A, Renova, Differin,Tazorac,Tretinoin)
Other _____

Are you sensitive to any skin care ingredients or cosmetics?
Yes No Last Date Used _____
Current Products being used on your skin Daytime:_____ **Nighttime:**_____

Have you recently received any of the following?
Face Treatment Date:_____ Microneedling Date:_____

Chemical Peel Date:_____ Ultherapy Date:_____Laser/IPL Date:_____

Have you ever had any of the following?
Botox Injections Date: _____ Restylane Injections Date:_____
Collagen Injections Date: _____ Skin Cancer Date: _____
Laser Resurfacing Date:_____ Rhytidectomy (Face Lift) Date:_____
Rhinoplasty (Nose) Date: _____ Blepharoplasty(EyeLift) Date:_____

Do you suffer from allergies? (Sulfa,food,iodine,medications,hay fever,latex)
Please Circle:
Yes No If yes, please specify:_____

Are you currently taking any medications, herbs or vitamins?
Yes No If yes, please specify: _____

How many glasses of water do you consume daily? _____

When exposed to the sun, do you? Please circle one
Burn Easily Tan Easily Never Burn Never Tan

Are you under a physician's care for any reason?
Yes No If Yes, please specify:_____

For women only: Please circle
HRT Menopause Pregnant Hormonal Birth Control

Do any of the following apply to you? Please Circle Smoker Wear Contacts
Pacemaker Pins in Bones Varicose Veins

Please note that waxing, facials, dermaplaning does have certain side effects such as skin irritation, redness, swelling, tenderness, and bruising. I understand I am responsible for following the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions/concerns regarding my treatment or suggested home product/home-treatment care, I will consult the esthetician immediately.

Cancellation Policy and Arriving Late- 24-hour notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. **There will be a fee of 50% of the scheduled service assessed to your account for any same-day cancellations or no-show clients.** If you arrive late, your session will be shortened to accommodate appointments that follow yours. Regardless of the length of the treatment given, the session will be charged in full.

Client Consent/Liability Waiver-*Massage/ bodywork/ Facials/ Lash & Brow services should not be performed under certain medical conditions.* The information that I provided is accurate and complete. I agree to keep Evolve informed of any changes in my medical profile and understand that there shall be no liability on Evolves' part should I fail to do so. The services I am scheduled for require person to person contact. By signing below, I am acknowledging this and giving permission to be treated at Evolve Massage and Wellness Center, LLC. Evolve Massage & Wellness Center is not responsible for any items that you may leave unattended. By signing this Agreement, I RELEASE OF LIABILITY AND AGREEMENT NOT TO SUE, INDEMNIFICATION, HOLD HARMLESS, LIMITATION OF WARRANTY Evolve Massage and Wellness Center responsible for contracting communicable/contagious diseases and conditions such as, but not limited to, Influenza, COVID-19, other viruses, and contagious skin conditions.
Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment for the scheduled appointment.

Client Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

Consent to Treat a Minor: The state of PA requires that a parent or guardian,, be physically present in the facility during treatment of a minor during massage. By signing this form, I hereby authorize Evolve Massage & Center LLC to administer facials, waxing, lash & Brow services and techniques to my child or dependent as they deem necessary.

Name of Minor: _____

Signature of Parent or Guardian: _____ **Date:** _____

STAFF USE ONLY:

SOCIAL MEDIA : I give permission to the Estheticians to take pictures and or videos during the session and to post said pictures and videos on Evolve's social media . **YES** **NO** **Client Initials** _____