Infinite Skin
Aesthetic Medical Spa

1665 43rd St S
Suite 108
Fargo, ND 58103
701-282-9642

NEW Client Intake Form

2022

General Information

Name: ______________________ *Today's Date:* ______________________

Address: ______________________

City, State, Zip: ______________________

Phone Number: ______________________ *Date of Birth:* ______________________

Email: ______________________

Emergency Contact Name: ______________________ *Phone Number:* ______________________

How did you hear about us? ______________________
If referred from a client please list their name so we can thank them!

Cancellation and Late Policy

The most valuable thing you can give someone is your time, and we fully believe that everyone's time should be respected. We understand sometimes it is necessary to reschedule or cancel an appointment; however, we ask that 24 hours notice is given prior to cancelling. **In the event that you are unable to give us a 24 hours notice, a cancellation or "No Show" fee of $50 will be charged to your card.** If you arrive more than 10 minutes late to your scheduled appointment, we have the right to ask you to reschedule. We apologize for any inconvenience this may cause.

______________________ ______________________
Client Signature Date

Skin History
Concerns *(Check all that apply):*

- ◯ Acne/Acne Scarring
- ◯ Brown Spots/Sun Damage
- ◯ Rosacea
- ◯ Melasma
- ◯ Large Pores
- ◯ Unwanted Hair
- ◯ Pigmented Lesions
- ◯ Flushing of the skin
- ◯ Crow's Feet
- ◯ Deep Lines/Shadows
- ◯ Skin Laxity
- ◯ Skin Texture/Scars
- ◯ Fine lines/Wrinkles
- ◯ Dry Skin
- ◯ Oily Skin

How long have you had any of the above concerns? ______________________

Are you currently being treated for any of the above conditions? **Y** **N**
If yes, please explain: ______________________

Are you currently taking any medications for a skin condition? **Y** **N**
If yes please list: ______________________

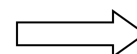
Have you or anyone in your family had skin cancer? **Y** **N**
If yes, please explain: ______________________

Have you had a reaction to lotions, creams, or oils? **Y** **N**
If yes, please explain: ______________________

Personal History:
Do you smoke? **Y** **N**
Do you drink alcohol? **Y** **N**
Do you wear Contact Lenses? **Y** **N**
Do you exercise regularly? **Y** **N**
Do you have any metal implants? **Y** **N**

Cosmetic History
Have you ever had Botox and/or Filler treatments? **Y** **N**

Have you had a reaction to ANY cosmetic procedure? (i.e. Botox, Fillers, Lasers, Chemical Peels)
If yes, please explain: ______________________



Medical History

*Please check **ALL** that apply to you:*

◯ Active Infection	◯ Cancer	◯ Hepatitis A, B or C	◯ Pacemaker/Defibrillator
◯ Alcoholism	◯ Chemical Dependency	◯ Herpes	◯ Pigmentation disorder
◯ Anemia	◯ Chest Pain	◯ High Blood Pressure	◯ Polycystic ovaries (PCOS)
◯ Anorexia	◯ Chronic Fatigue	◯ Hormone Imbalance	◯ Sensitive Teeth
◯ Arthritis	◯ Connective Tissue Disorder	◯ HIV/Aids	◯ Skin Cancer/Moles
◯ Asthma	◯ Diabetes	◯ Keloid Scarring	◯ Skin Injury/Lesions
◯ Autoimmune Disease	◯ Eating Disorders	◯ Migraines	◯ Thyroid Disorders
◯ Bleeding Disorders	◯ Epilepsy or seizures	◯ Multiple Sclerosis	◯ Vision Deficits
◯ Breast Lump	◯ Fibromyalgia	◯ Neurologic Disorder	
◯ Bruising	◯ Heart Disease	◯ Neuromuscular Disorder	

Are you taking any blood thinners? **Y** **N** Do you take Aspirin or Ibuprofen? **Y** **N**

Are you taking any supplements? (Vitamin E, Fish Oil, etc.) ____________________

Please list **ANY** Medications you are taking:

____

____

Please list **ANY** allergies: ____________________________________ ☐ NONE

Do you have any muscle issues (i.e. Strokes, Bell's Palsy, nerve injury)? **Y** **N**

If *yes*, please explain: ____

Please list any surgeries and dates of surgery:

____

____

(females) Are you pregnant or planning to become pregnant? **Y** **N** Are you nursing? **Y** **N**

Is there ANY other information you would like your technician to be aware of?

____

May we use your before and after photos **WITHOUT** identifying you in advertising? **Y** **N**

I have answered the questions contained in this questionnaire to the best of my knowledge. I understand it is my responsibility to inform my technician of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes to my health between treatments.

______________________________________ ____________________

Client Signature Date

Office use only

REVIEWD BY:

RN Name	*RN Signature*	*Date*
Medical Provider Name	*Medical Provider Signature*	*Date*