UNITY Medical Centre
2579 King St E. Hamilton, Ontario L8K 1Y4
Family & Urgent Care | Natural Medicine | Medical Aesthetics

ESTHETICS

NEW CLIENT INTAKE FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Esthetician _____

How did you learn about us? ☐ Social media ☐ A friend ☐ Online search ☐ Walked by

Are you on any medication? ☐ Yes ☐ No If yes, which ones _____

Do you exercise? ☐ Yes ☐ No If yes, how many times per week? ____ How many hours? ____

Are you pregnant? ☐ Yes ☐ No

**Please mark any of the following conditions you may currently have.

- ☐ Neck injury
- ☐ Infection
- ☐ Pms
- ☐ Emotional changes
- ☐ Sinus congestion
- ☐ Headaches
- ☐ Cold virus
- ☐ Flu
- ☐ Allergies
- ☐ Alcohol within 24hrs
- ☐ Kidney alignment
- ☐ Sports injury
- ☐ Phlebitis
- ☐ Bruises
- ☐ High Blood pressure
- ☐ Varicose veins
- ☐ Acute pain
- ☐ Grief process
- ☐ Recent surgery
- ☐ Open wounds
- ☐ Osteoporosis
- ☐ Chronic pains
- ☐ Blood clot
- ☐ Fever within 24hrs
- ☐ Wear contacts
- ☐ Others, please specify

List any other conditions you may have here:

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NEW CLIENT CONSENT FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Esthetician _____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment/procedure have been explained to me, along with the risks and hazards involved by _____.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize that there are no guaranteed results and that results are dependent upon age, skin condition, genetics, lifestyle and that there is a possibility that I may require further treatments of the treated areas to obtain to the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me with post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home 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 and prescription drugs or products I am currently ingesting or taking topically.

- If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort.
- I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment.
- I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of the session given should be construed as such.
- I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the esthetician's part should I fail to do so.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.
- The services offered are not a substitute for medical care, and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in the future.

Name: _____

Signature _____ Date: _____

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PHOTO & VIDEO RELEASE FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Esthetician _____

I, _____ hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute, and make use of any and all pictures, videos, and/or audio taken of me to be used in/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 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 ÜNITY Medical Centre from all liability, petitions, and causes of action which I, my heirs, representatives, executors, or any other persons make while acting on my behalf .

Name: _____

Signature _____ Date: _____

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SKIN ANALYSIS

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Esthetician _____

Have you had a facial or skin treatment before? ☐ Yes ☐ No Details: _____

What are your skincare goals? _____

SKIN HISTORY

SKIN TYPE

- ☐ Oily
- ☐ Dry
- ☐ Combination
- ☐ Normal
- ☐ Sensitive
- ☐ Acne Prone
- ☐ Unsure

SKIN CONCERNS

- ☐ Oil
- ☐ Dryness
- ☐ Acne
- ☐ Milia
- ☐ Fine Lines
- ☐ Dullness
- ☐ Hyperpigmentation
- ☐ Sun Damage
- ☐ Eczema
- ☐ Psoriasis
- ☐ Phlebitis
- ☐ Redness
- ☐ Black/Whiteheads
- ☐ Discoloration

List your current skincare routine and products:

_____

_____

_____

_____

_____

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CLIENT TREATMENT PLAN

Name _____ Date _____
Address _____ Emergency contact _____ Phone _____
Phone _____ Esthetician _____

TREATMENT 1	TREATMENT 2	TREATMENT 3
# of Days/Week:	# of Days/Week:	# of Days/Week:
End Date:	End Date:	End Date:

HOME CARE PLAN

PRODUCT	# PER WEEK	TIME OF DAY
		☐ Morning ☐ Evening
		☐ Morning ☐ Evening
		☐ Morning ☐ Evening
		☐ Morning ☐ Evening
		☐ Morning ☐ Evening

NOTES

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CLIENT TREATMENT RECORD

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

Phone _____ Esthetician _____

DATE	TREATMENT	PRICE	NOTES

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AESTHETICS SIGN IN

Date: _____

NO.	NAME	EMAIL	PHONE
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2			
3			
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