

# 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.

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

List any other conditions you may have here:

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# ESTHETICS

## 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: \_\_\_\_\_

# 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: \_\_\_\_\_

# 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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**Medical Centre**

Family & Urgent Care | Natural Medicine | Medical Aesthetics

2579 King St E. Hamilton, Ontario L8K 1Y4

# 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

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\_\_\_\_\_

Morning  Evening

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\_\_\_\_\_

Morning  Evening

## NOTES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# AESTHETICS SIGN IN

Date: \_\_\_\_\_

NO.	NAME	EMAIL	PHONE
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