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**Patient Intake Form**

Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth/Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there someone we can thank for recommending us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_

# Medical History

**Please circle any conditions you currently have or have had in the past.**

|  |  |  |
| --- | --- | --- |
| AIDS | Hay Fever | Radiation Treatment |
| Anemia | Heart Disease | Respiratory Problems |
| Arthritis | Hepatitis | Skin Conditions |
| Asthma/Allergies | High Blood Pressure | Sinus Problems |
| Autoimmune Disease | Infection | Stomach Problems |
| Blood Transfusion | Kidney Disease | Stroke |
| Chemotherapy | Liver Disease | Thyroid Problems |
| Cold sore/Fever Blister | Lupus | Surgery |
| Diabetes | Melanoma | Skin Cancer |
| Dizziness/Fainting | Nervous Disorder | CANCER OF ANY KIND |

Epilepsy

**ALLERGIES:**

**CURRENT MEDICATIONS:**

**Are you presently under a physician’s care for any current skin condition or other problem?**

If yes, please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant?** **Y N**

**Are you taking birth control pills or hormone replacement?** **Y N**

**Do you wear contact lenses?** **Y N**

**Do you smoke?** **Y N**

**What skin care products are you using now?**

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

**Have you used or are you currently using: (please circle)**

Retin A or similar product, Accutane, Other prescription Acne medication

**Have you ever had any of the following aesthetic or cosmetic services (please circle)**

|  |  |  |  |
| --- | --- | --- | --- |
| Facial Peel | Laser/IPL | Tattooing | Facial Surgery |
| Microdermabrasion | Botox | Permanent Makeup | Mesotherapy |

Dermaplaning Fillers Waxing

**If Yes, have you had any type of reaction to the procedure(s):**

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

**DISCLAIMER**

I understand that the services offered are not a substitute for medical care, and any information provided

by the provider is for treatment purpose only and not diagnostic or prescriptive in nature. I understand provider info is not diagnostic and that the information contained is to aid the provider in giving better service and is completely provider confidential.

**Policies:**

1. 24-hour notification of cancellation of appointment is required. If an appointment is cancelled with less than the required 24-hours, Pure Bliss Medical Spa reserves the right to charge a $50 cancellation fee.
2. It is recommended all clients have an initial consultation prior to any treatment.
3. For safety reasons, children are not permitted in treatment rooms or able to be left unattended in the med spa.
4. No refunds on retail products.

I HAVE COMPLETED THIS SURVEY ACCURATELY AND COMPLETELY. I fully understand and agree to the above policies.

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

PATIENT SIGNATURE. DATE