Between the Bridges Healing Center

Name: _____ DOB: _____

Date: _____

AESTHETIC INTAKE FORM

Have you been under medical care for any ongoing medical concern or diagnosis in the last year?
Y N
If yes, please specify on "Health History" form

Do you have a pacemaker and/or any metal implants (including in teeth)? Y N
If yes, please specify:_____

Do you have or have you ever been diagnosed with cancer? Y N
If yes, please specify what type of oncology treatment you received:_____

In the last year, have you received a facial or seen a Dermatologist? Y N
If yes, please specify**:**_____

Primary concern(s) for today's consult/treatment:_____

_____

Secondary concern(s) for today's consult/treatment:_____

_____

Have you addressed your concerns with a physician or aesthetician prior to today's treatment? Y N

Please circle the following skin concerns

*Acne *Broken Blood Vessels *Brown Spots *Crows Feet *Facial Dryness *Facial Oiliness

*Facial Volume Loss *Forehead Lines/Frown Lines *Lip Lines *Lip Volume Loss *Scarring

*Neck and Chest Discoloration *Nose-to Mouth Lines *Red Spots/Flushing *Skin Texture

*Thin, Short or Lightened Lashes *Under Eye Circles/Crepiness or Creping *Uneven Skin Texture

*Unwanted Hair *Changes in Skin Related to Oncology Care *Dullness

Please circle the following services of interest to you:

*Chemical peels *Facials/Body Facials *Cosmetic Laser Treatments *SPF Advice *Microneedling

*General Skin Health/Product Advice *Hair Removal *Hydrafacial *Microcurrent *Oncology Skin Care

Please describe any adverse reactions to previous cosmetic treatments:_____
Type of service that was received**:**_____

45 Teton Lane, Mankato, MN 56001 **Phone (507) 388-7488** Fax (507) 388-5680
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Please list all allergies:_____

Please describe any adverse reactions to topical skin care products, makeup, and medications:_____
_____

Are you currently using any form of: *Retin-A *Differin *Tazorac *Renova *Glycolic Acid *Salicylic Acid

*Benzoyl Peroxide *Hydroquinone *Other _____

Have you ever been on Accutane or other prescribed acne medication? Y N
If yes, date of last treatment: ____/____/____

Do you currently, or have you in the last month, take(n) any recommended supplements or prescribed medications? Y N
If yes, please list on "Medication Tracking Form"

Do you have a history of herpes simplex one (cold sores)? Y N

Do you currently take an anti viral medication for the prevention or treatment of cold sores? Y N

Do you have a history of lupus or any other autoimmune disease? Y N

Have you ever developed keloids (raised scars)? Y N

Do you tan on a regular basis or have you been tanning within the last month? Y N

Do you have a history of atypical moles, Melanoma or skin cancer in your family? Y N

Do you drink caffeinated beverages on a regular basis? Y N

Have you experienced claustrophobia? Y N

Do you have sinus problems? Y N

Do you exercise regularly? Y N

Do you follow a restricted diet? Y N

Do you smoke? Y N

For men: do you have any concerns with facial hair in relation to shaving (i.e. ingrown hairs, acne, uneven texture post shaving)? Y N

For women: are you pregnant, planning to become pregnant, or lactating (breastfeeding)? Y N

For women: are you menstruating or expecting your menstrual cycle soon? Y N
Please circle if any of the following applies to you:
*Post-menopausal *Pre-menopausal *Menopausal

Please describe your skincare regiment:
Cleanse AM:_____ Cleanse PM:_____
Toner/Astringent AM:_____ Toner/Astringent PM:_____
Prescriptions/Treatment Products AM:_____ Prescriptions/Treatment products PM:_____
Prevention/Serum Products AM:_____ Prevention/Serum Products PM: _____

Moisturizer/Creams AM:_____ Moisturizer/Creams PM:_____
SPF:_____

Weekly at-home facial treatments:
Masks/Scrubs/Other(s) list:_____

Does your skin ever flake or feel tight and dry? _____Frequently _____Occasionally _____Very Rarely

Do you feel oily a few hours after cleansing? Y N

Do you feel your current skin care regiment is addressing your primary and secondary concerns listed today? Y N
If no, please specify:_____

What are your expectations for today's consultation/treatment? _____
_____

(Please Read and Sign)

I understand that initializing here, all no call no show missed appointments for any Aesthetic service will incur a 50% charge of the service scheduled to be received. Initials:_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary.
Responsible Party: _____ Date: _____

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