Date \_\_\_\_\_\_\_\_\_\_

**Welcome to BU Wellness & Med Spa**

**Client Intake Form**

**Patient Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Phone Number: (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about us?** Facebook Instagram Internet Doctor Friend/Family

Newspaper Walk-in Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What changes you would most likely to see in your skin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you be interested in information regarding cosmetic procedures:**

*(circle all that apply)* Botox/Dysport, Fillers, Chemical Peels, Skin Resurfacing Dermaplane, Hydrafacial, Wrinkle Reduction, Laser Hair Removal, Age/Sun Spots Acne, Rosacea, Facial Veins, PRP Therapy, Mole/Wart Removal Other:\_\_\_\_\_\_\_\_\_\_

**About You**

**Ethinc Background:** White Asian Mediterranean Hispanic African American

Middle Eastern Native American Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Natural Eye Color : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Natural Hair Color \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Type** *(circle all that apply)* Normal Sensitive Dry Oily Combination Acne Rosacea Eczema Freckled Hyperpigmentation Sun-damaged Melasma Saggy Wrinkles Broken capillaries Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Lenses \_\_\_\_ Use Sunscreen \_\_\_\_ Tattoos or permanent make up \_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women only: Are you pregnant or lactating? \_\_\_\_ Yes \_\_\_\_ No

***We appreciate your family/friends referrals & Google/Yelp reviews!***

**Social History**

Vigorous exercise or sports? Yes \_\_\_\_ No \_\_\_\_

Do you smoke, vape or use tobacco? Yes \_\_\_\_ No \_\_\_\_

Do you drink alcohol? \_\_\_\_ Yes \_\_\_\_No If yes, how many drinks per week? \_\_\_\_\_\_

**Medical History**

**ALLERGIES??**  (medications, contrast dye, food or latex) Yes \_\_\_\_ No \_\_\_\_

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had in the past or currently have:** \_\_\_Diabetes \_\_\_Hypertension \_\_\_ Stroke \_\_\_Heart Disease \_\_\_Irregular Heart beat \_\_\_Thyroid Disease \_\_\_Asthma \_\_\_ Lupus \_\_\_Heart Attack \_\_\_ Seizure disorder \_\_\_Fainting \_\_\_Polycystic Ovary Disease \_\_\_\_Cancer \_\_\_Shingles \_\_\_Keloid \_\_\_\_Pacemaker \_\_\_Implants \_\_\_Herniated Disc OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries you have undergone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any of the following medications, topical or otherwise?

Tretinoin/Retin-A, Renova, Differin, Tazorac, Avage, EpiDuo, Ziana Yes \_\_\_\_\_ No \_\_\_\_\_

Have you taken **Accutane** (Isotretinoin) in the last 6 months? Yes \_\_\_\_\_ No \_\_\_\_\_

**Aesthetic/Skincare History**

Have you used **tanning beds** in the last 4 weeks? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had unprotected sun exposure in the last 4 weeks? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you planning to have sun exposure in the next 2 weeks? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you currently use depilatories or wax ? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had a chemical peel within last 2 weeks? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have regular Botox/Dysport or any dermal filler injections? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you recently had any facial resurfacing or facial surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had hair removal or Photorejuvenation? Yes \_\_\_\_\_ No \_\_\_\_\_

What kind of skincare products are you using? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**fffffffffffffffffffffffffffffffffff**

Patient Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date X\_\_\_\_\_\_\_\_\_\_\_\_**