AFFINITY
ACUPUNCTURE
& ROLFING

CONFIDENTIAL CLIENT INTAKE FORM

General Information

Name_____Birthdate_____
Address_____
City_____State_____Zip Code _____
Phone #_____Email_____
Occupation_____
Emergency Contact Name_____Phone # _____
Would you like to be added to our email list for specials and discounts? ☐Yes ☐No
How did you hear about us? _____

Medical History

Please check all that apply:

- ☐ Acne
- ☐ Diabetes
- ☐ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hypo Pigmentation
- ☐ Lupus
- ☐ Pregnant
- ☐ Seborrhea
- ☐ Hyper/Hypo Thyroid
- ☐ Food sensitivities
- ☐ Keloids
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Eczema
- ☐ Heart Condition
- ☐ HIV
- ☐ Insomnia
- ☐ Sinus Infection
- ☐ Psoriasis
- ☐ Shingles
- ☐ Warts
- ☐ Anemia
- ☐ Herpes
- ☐ Depression
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Hyper Pigmentation
- ☐ Low Blood Pressure
- ☐ Surgery: _____
- ☐ Rashes
- ☐ Skin Cancer
- ☐ Other: _____

Are you currently taking any medications? ☐Yes☐No
If yes, please explain: _____
Have you been on Accutane? _____

Do you have any allergies? ☐Yes ☐No
If yes, please explain: _____

Skin Care History

Check the products that you currently use (please select all that apply):

- ☐ Body Lotion
- ☐ Cleansing Cream
- ☐ Eye Cream
- ☐ Facial Scrub
- ☐ Night Cream
- ☐ Body Soap
- ☐ Day Cream
- ☐ Exfoliates
- ☐ Hand Cream
- ☐ Skin Toner/Astringent
- ☐ Body Scrub
- ☐ Eye Makeup Remover
- ☐ Facial Soap
- ☐ Neck Cream
- ☐ Other: _____

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

AFFINITY
ACUPUNCTURE
& ROLFING

Conditions you are currently experiencing today (please select all that apply):

☐Anxiety ☐Fatigue ☐Forgetfulness ☐ Headache
☐Inflammation ☐Insomnia ☐Muscle Cramps ☐ Stress

Do you have a family history of high level Fitzpatrick or a red head gene**?**_____

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐Acne/Breakouts ☐Blackheads/Whiteheads
☐Broken Capillaries ☐Clogged Pores
☐Dark Spots ☐Dryness
☐Excessive Oil/Shine ☐Redness
☐Rosacea ☐Scarring
☐Sun Damage ☐Uneven Skin Tone
☐Unwanted Hair ☐Wrinkles/Fine Lines
☐Other: _____

Have you had any facial or dermatology services in the past 30 days? ☐Yes☐No
If yes, please explain: _____

Have you been under the care of a dermatologist within the past year? ☐Yes ☐No
If yes, please explain: _____

Have you used Retin-A, Renova, AHAs, Retinal/Vitamin A products in the last three months? ☐Yes☐No
If yes, please explain: _____
Have you received Botox, Restylane, or Collagen injections in the last 6 months?
☐Yes ☐No

By signing below, I agree to the following:

- I agree that I do not have any condition(s) that would make the requested treatment unsuitable.
- I fully understand this agreement and all information detailed to me, including the procedure and risks.
- I will inform the esthetician/acupuncturist of any discomfort I experience during my treatment to allow them to adjust accordingly.
- I understand my home care instructions and if I have additional questions or concerns, I will consult the esthetician/acupuncturist.
- I agree to waive all liability toward my esthetician/acupuncturist and the clinic for any injury/damages incurred due to misrepresentation of my health.

Signature_____Date_____

AFFINITY
ACUPUNCTURE
& ROLFING

Clinic Policies

24- Hour Cancellation Policy

We understand that you may need to cancel or change your appointment. In order to maintain quality patient-centered care, we require a 24-hour cancellation notice when you are unable to keep your scheduled appointment; otherwise you will be charged full price of your scheduled service.

I have read and understand the above policy.

Signature_____Date_____

Covid-19 Policy

Are you vaccinated? _____ Have you received a booster? _____
Vaccine type _____Dates of vaccination _____

No clients will be treated in the clinic with any viral symptoms such as a fever, cough, or shortness of breath.
I have read and understand the above policy.\

Signature_____Date_____