

# reVive

## client intake form

In order to provide you with the most effective treatment, I need to know as much about you, your life, and your lifestyle as possible. Please fill out the following profile to the best of your ability. If you have any questions or problems, please do not hesitate to ask for help. Be assured that this profile will be kept in the strictest of confidence.

Date: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

\_\_\_\_\_ How many hours per week do you work? \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

1. Are you currently under a doctor's care? Yes  No  For what? \_\_\_\_\_

2. Do you have metal implants or a pacemaker? Yes  No

3. Are you taking any medications? Yes  No  What and Why? \_\_\_\_\_

4. Are you taking any vitamins or herbs? Yes  No  What and Why? \_\_\_\_\_

5. Have you had any recent operations or major illnesses? Yes  No  What and when? \_\_\_\_\_

6. Any major injuries or accidents? Yes  No  What and when? \_\_\_\_\_

7. Are you pregnant? Yes  No  Nursing? Yes  No

8. List allergies: \_\_\_\_\_

9. Have you or are you currently using the drug Retin-A or Renova? Yes  No  If yes, when? \_\_\_\_\_

10. Please check any of the following which apply to you:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Insomnia           | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcer             |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Psoriasis          | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seborrhea          |  |
| <input type="checkbox"/> Colitis         | <input type="checkbox"/> Hormone Imbalance   | <input type="checkbox"/> Systemic Disease   |  |

If you checked any of the above, please explain each: \_\_\_\_\_

11. Are you a smoker? Yes  No  Amount? \_\_\_\_\_

12. Do you have any particular areas you hold tension, i.e. shoulders, back, neck? \_\_\_\_\_

13. What type of massage pressure do you prefer? Soft  Medium  Hard

14. Do you have a regular exercise program? Yes  No  How often? \_\_\_\_\_ Type? \_\_\_\_\_

15. Are you on a restricted diet now? Yes  No  Doctor's Supervision? Yes  No

Explain if so \_\_\_\_\_

Weight Loss Program? Yes  No  Other? \_\_\_\_\_

Sleep Pattern: \_\_\_\_\_ hours per night

16. How often do you consume the following?

Water \_\_\_\_\_ Glasses Per Day Soda \_\_\_\_\_ Glasses Per Day Coffee/Tea \_\_\_\_\_ Cups Per Day

Alcoholic Beverages \_\_\_\_\_ Per Week

Servings of Fruit \_\_\_\_\_ Vegetables \_\_\_\_\_ Per Day

17. Have you ever had a reaction to a skin care product? Yes  No  What was the product or ingredient? \_\_\_\_\_

18. Describe in detail (product names - if possible) how you are presently caring for your skin.

A.M. \_\_\_\_\_

P.M. \_\_\_\_\_

19. Your Skin Concerns:

- |   |  |
|---|--|
| <input type="checkbox"/> excess oiliness                | <input type="checkbox"/> hyperpigmentation                         |
| <input type="checkbox"/> breakouts & blackheads         | (sunsports or marks from breakouts)                                |
| <input type="checkbox"/> tired, dull, in need of a glow | <input type="checkbox"/> redness/sensitivity or uneven complexion  |
| <input type="checkbox"/> dry skin                       | <input type="checkbox"/> lack of firmness/elasticity               |
| <input type="checkbox"/> puffy eyes                     | <input type="checkbox"/> would like smoother, more refined texture |
| <input type="checkbox"/> dry/fine lines around eyes     | <input type="checkbox"/> interested in anti-aging solutions        |

20. Have you ever been under a dermatologist's care? Yes  No  When? \_\_\_\_\_  
How long? \_\_\_\_\_ For what condition(s)? \_\_\_\_\_

21. Have you ever had a skin treatment before? Yes  No  If so, what did you like or dislike about the experience? \_\_\_\_\_  
\_\_\_\_\_

*Treatments you select are reserved especially for you. We reserve the right to charge for cancellations of less than 24 hours.*

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