YuraMed
826 BUSTLETON PIKE, UNIT 101 A
FEASTERVILLE, PA 19053
215-305-8206

Aesthetic Services Intake Form

Today's Date _____ Date of Birth/ Age _____/_____

First Name _____Last Name _____

Street Address _____ Apt. # _____

City _____ State _____ Zip_____

Phone H (____) _____Cell (_____)_____

Emergency Contact Name _____Phone (_____) _____

Email _____Is there someone we can thank for recommending us? _____

What is the reason for your visit today? _____

What special areas of concern do you have? _____

Are you presently under a physician's care for any current skin condition or other problem _____

How much plain water do you consume daily? _____

Customer Medical History

Medical History (Please circle any conditions you currently have or have had in the past)

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

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

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Diabetes	Melanoma	Skin Cancer
Dizziness/Fainting	Nervous Disorder	CANCER OF ANY KIND
Epilepsy	MRSA	Acne

Other _____

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

Are you currently having or will soon have your menstrual period? **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**

Allergies_____

Please list all current medications, supplements you are taking:

_____

2. Skin History

1. What temperature of water do you cleanse with? _____

2. What skin care products are you using now? _____

3. Do you burn easily? **Y** **N**

4. Do you wear SPF? **Y** **N**

5. Do you experience breakouts? **Y** **N**

6. What are your skin care goals? _____

7. Have you ever used or are you currently using: (please circle)

Retin A or similar product **Accutane** Tazarac Glycolic or Alphahydroxy Acids Azelex Differin
Other prescription Acne medication_____

8. 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	

9. Do you have acne? Yes No

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Disclaimer

I understand that the services offered are not a substitute for medical care. If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated. I HAVE COMPLETED THIS SURVEY ACCURATELY AND COMPLETELY. I fully understand and agree to the above policies.

Client Signature _____ Date _____

NAME: _____

ASTHETICIAN'S/ESTHETICIAN'S NAME: _____Date_____

FOR STAFF USE ONLY:

Skin Type	Normal	Oily	Dry	Combination
Condition	Texture		Pigmentation	
	Sun Damage		Rosacea	
	Acne		Sensitivity	

Areas of Concern

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1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize YURAMED to take preprocedural, procedural, and post-procedural photographs, slides, and/or videotapes.

I consent to the use of these images for the purposes of pre-procedural planning and post-procedural evaluation.

Patient Signature: _____ Date:_____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby **YURAMED** to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, or during lectures to medical or lay groups for the purposes of informing the local community or the general public about aesthetic procedures, medical spa treatments available at **YURAMED, LLC**. Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. This permission may be rescinded by me at any time to prohibit future.

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Patient Signature: _____ Date:_____

Parent or Guardian (if patient is under 18 years of age): _____

Witness: _____