VIBRANTHEALTH
nourish · revitalize · transform

Aesthetic Intake Form

First and Last Name: _____
DOB: _____ Today's Date: _____
Address: _____
City: _____ State: ____ Zip: _____
Telephone: _____ Mobile: _____ Ok to leave message: Y N
E-Mail: _____
Occupation: _____ How did you hear about us: _____
Primary Care Provider: _____
Pharmacy: _____
In order of importance, beginning with number 1, please rate what you would like to see improved in your skin:
____ Reduction of fine lines/wrinkles ____Reduction of brown spots/sun damage ____Reduction of oil/acne
____ Reduction of redness
____ Other: _____

Please answer the following questions:

1. Do you have ***any*** current or chronic medical conditions? ___YES ___NO
   Please disclose any history of heat uticaria, diabetes, autoimmune disorders, or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or any other condition or illness.
   _____
   _____
   _____
   _____
2. Are you currently under a doctor's care? If so, for what reason?
   _____
   _____
   _____
3. Have you ever had Gold Therapy Treatment (chrysotherapy, aurotherapy, Gold sodium thiomalate (GST)?
   ___YES ___NO
4. Are there any topical products (both medical and non-medical) that you use on your skin on a regular basis?
   _____
   _____
   _____
   _____
   _____
   _____

Name: _____ DOB:_____ Today's Date: _____

Please indicate all medical history, past and present

	Yes	No		Yes	No
Are you or is it possible you may pregnant?			Keloid scarring		
Are you breastfeeding?			Cold sores		
Do you form thick or raised scars from cuts or burns?			Herpes (genital)		
After injury to the skin (such as cuts/ burns) do you have: -Darkening of the skin in that area (hypergimentation) -Lightening of the skin in that area (hypopigmentation)			Easy bruising or bleeding		
Hair removal by plucking, waxing, electrolysis or depilatory creams in the last 4 weeks?			Active skin infection		
Tanning (tanning bed) or sun exposure in the last 4 weeks?			Moles that have recently changed, itched or bled		
Tanning products or spray on tan in the last 2 weeks?			Recent increase in amount of hair		
Do you have a tan now in the area to be treated?			Asthma		
Do you use sunscreen daily with SPF 30 or greater?			Seasonal allergies/allergic rhinitis		
Have you ever had a skin cancer?			Eczema		
Have you ever had a photosensitive disorder? (e.g. lupus)			Thyroid imbalance		
Do you have a personal history of seizures, or light induced seizures?			Poor healing		
Permanent make up or tattoo?			Diabetes		
In the last six months, have you used: Acutane, anticoagulants or blood thinning medications, photosensitizing medications, or anti inflammatory medications? Which: _____ _____			Diseases of nerves or muscles (e.g. ALS, Myasthenia gravis, Lambert-Eaton or other)		

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Are you currently taking any antibiotics? Which:			High blood pressure		
Are you using Retin-A or Glycolic products?			Pacemaker		
Do take/use ANY systemic/oral steroids (e.g. prednisone, dexamethasone)?			Autoimmune disease (e.g. rheumatoid arthritis, Scleroderma)		
Do you have any open sores or lesions?			HIV/AIDS		
Do you currently smoke?			Heart condition		
Do you have scars on the face?			Hepatitis		
Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to collagen, autologous fast, Restylane, etc? List location in body, date:			Do you have or have you ever had any Botulinums such as Botox® or Dysport®? List location in body, date:		
Explanation of anything marked "yes:"			Migraine headaches		
			Shingles		
			Other:		

Medication	*Dosage*	*Frequency*	*Reason for taking*

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Please list ALL prescription medications, supplements and over-the-counter medications

Please list all allergies/intolerances

Allergy/Intolerance	Reaction	Date of Onset

Signature: _____Date: _____