ADVANCE AESTHETICS LUXEMBOURG

FACIAL INTAKE FORM

PERSONAL INFORMATION

Name: _____________________ Date of Birth: ___/___/____ Gender: ☐ M ☐ F ☐ O
Address: ____
City: _______________________ State: _________________ Zip: ________________
Phone Number: _________________ Email Address: _____________________________

PERSONAL HEALTH HISTORY

Do you have any of the following conditions? If yes, please select them:

- ☐ Blood Clot Disorder
- ☐ Blush Easily
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Circulation Disorder
- ☐ Claustrophobia
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Eczema
- ☐ Epilepsy or Seizures
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Hepatitis A/B/C
- ☐ HIV AIDS
- ☐ Hormonal Imbalance
- ☐ Hypertension
- ☐ Hypotension
- ☐ Hysterectomy
- ☐ Immune Disorder
- ☐ Keloid Scaring
- ☐ Lupus
- ☐ Menopause
- ☐ Metal Implants
- ☐ Migraines/Headaches
- ☐ Other
- ☐ Pacemaker or Defibrillator
- ☐ Psoriasis Rosacea
- ☐ Skin Disease
- ☐ Spinal Cord Injury
- ☐ Thyroid Disorder
- ☐ Varicose Veins

SKIN CARE HISTORY

WHAT IS YOUR SKIN TYPE?	HOW DOES YOUR SKIN HEAL?	YOUR CURRENT SKIN PRODUCTS?
☐ Normal	☐ Fast	Product Name:
☐ Oily	☐ Slow	
☐ Dry	☐ Pigments	Purpose:
☐ Acne	☐ Scars	
☐ Other	☐ Other	Frequency:

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SKIN CARE HISTORY

☐ Eye Make-Up Remover	☐ Day Cream	☐ Mask
☐ Cleansing Cream	☐ Night Cream	☐ Facial Scrub
☐ Facial Soap	☐ Eye Cream	☐ Exfoliants
☐ Skin Toner/ Astringent	☐ Neck Cream	☐ Body Lotion/Cream
☐ Body Soap	☐ Hand Cream	☐ Body Scrub

SOCIAL HISTORY

Question	Yes	No
Have you undergone any surgeries?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you taking any contraceptive pills?	☐ Yes	☐ No
Are you trying or planning to be pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No
Are you currently under any kind of diet?	☐ Yes	☐ No
Are you wearing any contact lenses?	☐ Yes	☐ No
Do you consume caffeinated drinks?	☐ Yes	☐ No
Do you consume alcohol?	☐ Yes	☐ No

TERMS & CONDITIONS

- I understand that my data will be strictly confidential. This clinic does not sell, share, or resell information.
- I confirm that all information in this form is true and accurate.
- I confirm that if I hold some important information and complications happened, the clinic will not be liable.
- I release this clinic and hold harmless against any claims, expenses, damages, and liabilities.
- I understand and agree to the terms and conditions.

CLIENT

Name:_________________________

Signature:______________________

Date:___________________________

ESTHETICIAN/TECHNICIAN

Name:_________________________

Signature:______________________

Date:___________________________