HYDRA BEAUTY SKIN SYSTEM FACIAL
CLIENT INTAKE FORM

APPOINTMENT DATE: ____________________ APPOINTMENT TIME: ____________________

NAME:	AGE:	GENDER:
ADDRESS:	ZIP:	STATE:
EMAIL:	PHONE:	

Opt-in for email list to receive information & offers: ☐ Yes ☐ No

How did you hear about us? ☐ Friends/Family ☐ Social Media Other: ____________________

What are your long-term skin goals? ____________________

Have you ever had professional skin care treatments previously? ☐ Yes ☐ No

If yes, please explain: ____________________

What skin care products do you use presently? ____________________

Exposure to sun? ☐ Light ☐ Moderate ☐ Excessive

MEDICAL INFORMATION:

Have you ever had any of these conditions ? If NONE apply, please tick ☐ here:

YES	*NO*	
☐	☐	1. Accutane or other similar medication, Please List: ______________________________
☐	☐	2. Autoimmune disease, HIV, lupus, hepatitis, scleroderma
☐	☐	3. Any products containing Retinols, Glycolic, or skin lightning or bleaching agents.
☐	☐	4. Blood thinners – Heparin, Coumadin, Warfarin, Daily Aspirin/NSAID or vitamin E, etc.
☐	☐	5. Cold sores or fever blisters without pre-medication
☐	☐	6. Breastfeeding, pregnancy (for female clients)
☐	☐	7. Cortisone or steroid injections
☐	☐	8. Cosmetic injections, fillers or implants, (i.e. Botox®, collagen) Within last 7 days?
☐	☐	9. Enlarged or painful glands
☐	☐	10. Facial waxing services w/in 7-14 days
☐	☐	11. Inflammatory conditions
☐	☐	12. Epilepsy
☐	☐	13. Eczema, psoriasis
☐	☐	14. Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
☐	☐	15. Keloids, pigmented scars, icepick scars, new scar tissue
☐	☐	16. Laser procedures, chemical peels, dermabrasion, microdermabrasion
☐	☐	17. Loose, thin, aged skin
☐	☐	18. Lymphatic disorder, inflammation of lymph vessels, lymphedema
☐	☐	19. Keloids, pigmented scars, icepick scars, new scar tissue
☐	☐	20. Rosacea telangiectasia/couperose
☐	☐	21. Retin-A, Retinol
☐	☐	22. Skin-lightening or bleaching agent
☐	☐	23. Thyroid conditions
☐	☐	24. Type I diabetic
☐	☐	25. Viral infection, influenza (Current)

Other contraindication at discretion of skincare technician or medical practitioner:

If you answered YES to any of the above questions, please explain:

List all medications you are taking: ______________________
[including OTC drugs, vitamins etc.]

Are you under medical care for an existing or suspected condition or disease? ☐ Yes ☐ No

If yes, please explain: ______________________

Please list any allergies you have: ______________________
[Including cosmetics or Ingredients]

Is there anything else that should be known before starting your treatment?

GENERAL INFORMATIONS:

My interest in skincare treatment is primarily for (i.e. skin rejuvenation, hyperpigmentation, scarring, etc.)

Specify your areas of concern (i.e. eyes, forehead, etc.) ______________________

What are your long-term skin goals? ______________________

What are your goals from today's treatment? ______________________

Have you ever had professional skin care treatments previously? ☐ Yes ☐ No

If yes, please explain: ______________________

Do you wear contact lenses? ☐ Yes ☐ No

FOR FEMALE CLIENTS:

Are you taking any birth control pills?? ☐ Yes ☐ No

If yes, please specify: ______________________

Any menopause problems? ☐ Yes ☐ No

If yes, please explain: ______________________

Are you on hormone-replacement therapy? ☐ Yes ☐ No

If yes, please explain: ______________________

I have read the above information and have given an accurate account of the questions. If I have any concerns, I will address these with my esthetician before the service. I understand that the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature. I give permission to my esthetician to perform the hydra facial service and will not hold the esthetician nor the establishment accountable for any liability that may result from this treatment. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

Client Name	Client Signature	Date:
Esthetician Name	Esthetician Signature	Date:

HYDRA BEAUTY SKIN SYSTEM FACIAL
CLIENT CONSENT FORM

HYDRA BEAUTY SKIN SYSTEM FACIAL is the only hydradermabrasion procedure that combines cleansing, exfoliation, extraction, hydration and antioxidant protection simultaneously, resulting in clearer, more beautiful skin with little-to-no downtime. The treatment is soothing, moisturizing, non-invasive and generally non-irritating. As with most procedures, visible results from HydraFacial will vary from person to person.

What to expect:

- Your skin may experience temporary irritation, tightness, or redness. These are all normal reactions that typically resolve within 72 hours, depending on skin sensitivity.
- You may experience tingling and stinging in the treatment area. These sensations generally subside within a few hours.
- Patient experiences may vary. Some patients may experience a delayed onset of these symptoms.
- You will likely see results immediately after treatment, and your skin may feel smooth and hydrated for one to four weeks with appropriate home care to maintain treatment results.
- The skin is more susceptible to sunburn/sun damage. Avoid excessive sun exposure and use a minimum of SPF 30 sunscreen.

Please Initial:

___ I will avoid the use of aggressive exfoliation, waxing, and products containing glycolic acids or retinols that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre-and post-treatment.

___ Photos may be taken before, during and after the HydraFacial treatment. Photos will only be used with my written approval for education, promotion or advertising purposes

___ I agree to apply a sunblock with an SPF of 30 (minimum) after the procedure.

___ The information provided has been explained to me and all my questions have been answered to my satisfaction. I have read the above information, and I give my consent to have the HydraFacial treatment by the staff at: ____

___ By signing below, I acknowledge that I have read the above information and give my consent to be treated with the HydraFacial System. This consent form Is valid for all future HydraFacial treatments. I will alert the staff If there are any future changes to my medical history.

Client Name	Client Signature	Date
Esthetician Name	Esthetician Signature	Date