Date

Radio Frequency Intake

Personal Information

Name | DOB | AGE

Address

Phone | Occupation

Email

Are you pregnant or lactating?	Yes	No
Do you wear contact lenses/glasses?	Yes	No
Do you have any heart problems/conditions/disease? Please list:_____	Yes	No
Do you currently have high/low blood pressure?	Yes	No
Do you currently have any open wounds? Please list:_____	Yes	No
Do you currently or regularly use ORAL or TOPICAL medications (Accutane, Retin-A, Renova, Differin, Tazorac, Benzoyl Peroxide, or Other)? If yes, please list:_____	Yes	No
Have you ever had a seizure or been diagnosed with epilepsy?	Yes	No
Do you have an autoimmune disorder or connective tissue disease?	Yes	No
Do you receive Botox, Filler or Other?	Yes	No
Do you smoke or vape?	Yes	No
Have you had any previous facial treatments? Please list:_____	Yes	No
Do you take any medications that cause photosensitivity/light sensitivity?	Yes	No

By signing below, you agree to the following:
I have completed this form to the best of my ability and knowledge and agree to inform my esthetician of any changes to the information listed on all the pages of this client intake form. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform my esthetician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my esthetician and "COMPANY NAME HERE" for any injury or damages incurred due to my misrepresentation of my health history.

Signature

Date