Apex Massage and Wellness

3410 Frankfort Ave
Louisville, KY 40207
(502) 895-1262

Facial Intake Form

General Information

Name_____Date_____
Address_____City_____State_____Zip_____
Phone_____ Occupation_____ Date of Birth_____
How did you hear about us? _____ Email_____

Current Skin Care Routine – please list brands

Cleanser_____
Exfoliant_____
Toner_____
Serums or Essences_____
Moisturizer_____
SPF_____

Skin Care History

Have you ever had a facial? _____
Have you ever taken or are you currently taking isotretinoin (Accutane)? _____
Do you use retinol, Retin-A, Renova, or any other retinol derivatives? _____
If so, how recently and for how long? _____
Have you ever taken acne medication? _____ What kind? _____ How long? _____
Have you ever had a chemical peel, microdermabrasion, or any laser treatments? _____
Please detail_____

Skin Care Goals

Please describe the main reason for your visit today_____
When did you first notice this? _____
Is it progressively getting worse/better? _____
Has there been a diagnosis? _____

Medical History

List all medications you currently take? _____
_____
Please list any major past or current medical issues or major traumas/diseases in your health history_____
List any current allergies_____

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Review of Symptoms

Please fill this out carefully, even if some of the symptoms don't seem at all connected to your current issue. Place **one check** next to a symptom you have experienced, **two checks** next to a frequently occurring symptom, and **three checks** next to a symptom that is particularly distressing to you.

Skin Texture
Dryness ☐☐☐
Oiliness ☐☐☐
Itchiness ☐☐☐
Tightness ☐☐☐
Other_____

Acne
Blackheads ☐☐☐
Closed Comedones ☐☐☐
Pimples ☐☐☐
Cysts ☐☐☐

Appearance
Fine Lines/Wrinkles ☐☐☐
Redness ☐☐☐
Dark Spots ☐☐☐
White Spots ☐☐☐

Mental Health
Anxiety ☐☐☐
Depression ☐☐☐
Insomnia ☐☐☐
Stress ☐☐☐

Head and Face
Headaches ☐☐☐
Dizziness ☐☐☐
Other_____

Heart and Chest
High Blood Pressure ☐☐☐
Low Blood Pressure ☐☐☐
Chest Pain ☐☐☐
Chest Tightness ☐☐☐
Difficulty Lying Down ☐☐☐
Other_____

Nose
Frequent Colds ☐☐☐
Sinus Trouble ☐☐☐
Bleeding ☐☐☐
Other_____

Respiration
Difficulty Inhaling ☐☐☐
Difficulty Exhaling ☐☐☐
Pain ☐☐☐
Cough ☐☐☐
Congestion ☐☐☐
Shortness of Breath ☐☐☐
Other_____

Eyes
Blurry Vision ☐☐☐
Eyelid Twitching ☐☐☐
Floaters ☐☐☐
Pain ☐☐☐
Other_____

Circulation
Easy Bruising ☐☐☐
Easy Bleeding ☐☐☐
Cold Limbs - Hands or Feet ☐☐☐
Other_____

Contraindications that will prohibit services

Open wounds or infections, active herpes simplex 1 or 2, certain antibiotics or medications, sunburn, certain allergies, active rash, dermatitis, conjunctivitis (pink eye), or cold/flu.

Contraindications that could prohibit certain services

Certain services will be available to those with some of these conditions, however it will be on a case by case basis to be discussed with your provider. Metal implants, epilepsy, cardiac pacemakers, pregnancy, claustrophobia, recent chemical peels, Accutane, retinols, serious medical conditions (heart disease, diabetes, etc).

Parent/Guardian Signature_____ Date____/_____/_____

Printed Patient Name_____ Signature_____