THE PEELING COMPANY

Intake Form

Before we proceed to a treatment, we ask our clients to answer a number of questions prior to the intake interview, such as; your medical history, possible allergies and medication use. In order to be able to anticipate any risks and to treat your skin in a safe way. We will treat your data confidentially.

Personalia

Name:----------
Address:----------
Postal code / residence:----------
Date of birth:----------
Phone / mobile:----------
E-mail address:----------
How did you find us----------

Overall health		
Are you currently under the guidance of a dermatologist?	yes / no *	If yes, please specify;
Are you currently using medication / nutritional supplements	yes / no *	If yes, please specify;
Do you suffer from allergies?	yes / no *	If yes, please specify;
Do you use hormonal contraception?	yes / no *	If yes, please specify;
Are you currently pregnant?	yes / no *	
Are you following a diet?	yes / no *	If yes, please specify;
Indicate your stress level on a scale of 1 to 5 (1 = little and 5 = a lot)		

Do you suffer or have suffered from one of the following disorders?	
Recurrent herpes infections (cold sores)	yes / no *
Menstrual disorder	yes / no *
Intestinal problems?	yes/ no*
Hepatitis or AIDS or HIV positive	yes / no *
Haemophilia or increased bleeding tendency	yes / no*
Skin disorders (e.g., for example psoriasis, eczema, (pre-stages of) skin cancer	yes / no *
Diabetes or autoimmune diseases (e.g. SLE)	yes / no *

Skincare		
What would you like to improve on your skin?		
Do you use the following skin care products?	Cleanser? yes / no * Day cream? yes / no * Night cream? yes / no * Eye cream? yes / no * Serum? yes / no * Peeling/ Scrub? yes / no * Mask? yes / no *	
Do you use an SPF daily? (Sun protection)	yes / no *	
Do you sometimes use the sunbed?	yes / no *	
Have you been on holiday to the sun for the past 2 weeks?	yes / no *	
Will you go to the sun on holiday within two weeks?	yes / no *	
Do you have a tendency to redness?	yes / no *	
Do you ever experience burning, itching or stinging sensation on your skin?	yes/ no *	If so, please specify;

Treatment history		
Have you undergone the following treatments in the past?		
Chemical peeling?	yes / no *	If yes, when for the last time?
Microdermabrasion?	yes / no *	If yes, when for the last time?
IPL/ Laser treatment?	yes / no *	If yes, when for the last time?
Face wax	yes / no *	If yes, when for the last time?
Microneedling?	yes / no *	If yes, when for the last time?

Is there anything else your practitioner should know?	
yes / no *	If yes, please specify;

I have answered all questions truthfully
If there are any changes in the information above, I will inform my therapist prior to each treatment. I hereby give permission to carry out the treatment and process my data. We will deal confidentially with the information you give us. When processing personal data, we take into account the applicable laws and regulations in the area of privacy.

Place:

Date:

Client name: ---------- **Signature:** ----------