



PRINCESS/DUCHESS INTAKE FORM

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

(Your email address will be used for appointment confirmations, quarterly newsletters, and to alert you of specials and promotions.)

How were you referred to Bella Via? _____

SKIN SPECIFICS

How would you describe your skin? (circle all that apply)

Acneic/Acne-Prone

Dry

Normal

Oily

What type of skin do you have?

Sensitive

Resilient

Unsure

Have you ever had a facial?

Yes

No

Are you currently using any prescription skincare products?

Yes

No

If yes, which products? _____ How long? _____

How frequently? _____ Where do you apply it? _____

Do you wear contact lenses?

Yes

No

Do you develop cold sores and/or fever blisters?

Yes

No

If yes, when was your last breakout? _____

Please circle all allergies and/or sensitivities:

Aloe Vera

Apples

Aspirin

Citrus

Grapes

Hydroquinone

Latex

Milk

Perfumes

Other: _____

Please list all drug allergies: _____

What is your eye color? _____ What is your hair color? _____

Have you ever used any skincare products that caused a negative reaction?

Yes

No

If yes, please list products and describe reaction: _____

List all skincare products that you are currently using: _____

List all medications, herbals, and vitamins that you are currently taking: _____

Do you have or have you had any other medical condition(s) that your aesthetician should know about?

If yes, please explain: _____

Would you like your parent/guardian to be in the treatment room with you during your facial/makeup? Yes No

BODY SPECIFICS

Do you have circulation problems or do you bruise easily? _____

Do you have any allergies to lotions/oils, seaweed/iodine, or medications? _____

Do you have any other medical condition(s) that your massage therapist should know about? If yes, please explain: _____

Are you interested in aromatherapy incorporated into your treatment today? _____

Where are your specific areas of complaint, pain or tension? _____

Have you had a professional massage before? _____

Are you especially sensitive to touch/pressure in any specific areas? _____

Do you get muscle cramps? If yes, where? _____

Would you like your parent/guardian to be in the treatment room with you during your massage? Yes No

Client Signature: _____

Date: _____

Parent/Guardian Signature: _____

Thank you for visiting Bella Via!



Affiliated with Reconstructive &
Aesthetic Surgeons, Inc.
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