BELLA VIA
Skin and Body Therapies

SKINCARE TREATMENTS INTAKE FORM

Name:_____ DOB:_____ Age:_____ Gender:_____

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

Home Phone:_____ Cell:_____ Work: _____

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 originally referred to Bella Via? (Please circle and add note if applicable)
Dr. Colville Dr. Zavell Website Friend: _____
Other: _____

Airline Travel: Yes No How Frequently:_____

SKIN SPECIFICS

What are your expectations of the skin treatment you will receive today?_____
_____

If time allows, would you like to add any extra services to your skincare procedure today, such as waxing or paraffin for the hands and/or feet?_____

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

Acne Scarred	Asphyxiated	Breakouts	Combination	Comedones
Cysts	Dry	Firm	Florid/Flushed	Freckled
Hyperpigmented	Hypopigmented	Large Pores	Mature	Melasma
Milia	Normal	Oily	Oily T-Zone	Patchy Dryness
Perfume-Stained	Psoriasis	Rosacea	Saggy	Sallow/Yellowed
Small Pores	Sun-Damaged	Thick	Uneven	Wrinkled

Telangiectasia (Broken Surface Capillaries)

What type of skin do you have?	Sensitive	Resilient	Unsure
Are you sensitive to alcohol-based products?	Yes	No	
Have you ever had a peel?	Yes	No	
Have you had a peel within the last 14 days?	Yes	No	
If yes, please describe the type and your reactions to the peel _____			
Are you currently having microdermabrasion?	Yes	No	
If yes, how long has it been since your last treatment?_____			
Have you recently had laser resurfacing?	Yes	No	
If yes, please describe type and list approximate date_____			
Do you have regular collagen injections?	Yes	No	
Do you have regular Botox injections?	Yes	No	
Are you currently using Accutane?	Yes	No	
If yes, how long have you been using it?_____			
Are you currently using Tazorac, Retin-A, Renova, or Differin?	Yes	No	
If yes, what strength?_____ How long?_____			
How frequently?_____Where do you apply it?_____			
Are you currently using Bioré/snore strips?	Yes	No	

HEALTH AND LIFESTYLE

Do you wear contact lenses? Yes No
Do you tan via artificial tanning beds or booths? Yes No
If yes, when was your last visit?_____
Do you participate in vigorous aerobic activity or sports? Yes No
Are you pregnant or lactating? Yes No
(If yes, you may only receive the Oxy Trio or Detox treatment.)
Have you had your hair colored in the last 3 days? Yes No
Do you plan on getting your hair colored in the next 3 days? Yes No
Do you use a buff-puff to cleanse your face? Yes No
If yes, how often?_____ Has it been within the last 3 days?_____
Have you had facial waxing within the last 3-5 days? Yes No
Have you shaved your face within the last 3-5 days? Yes No
Do you smoke? Yes No
Do you develop cold sores and/or fever blisters? Yes No
If yes, when was your last breakout?_____
Do you currently have a sunburned/windburned/red face? Yes No
If yes, please list reason:_____
Are you planning to attend a special event (wedding, reunion, other)? If so, when?_____
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 natural hair color?_____

What is your skin tone?	Pale/Fair	Light	Medium	Reddish
	Freckled	Light Olive	Medium Olive	Dark Olive	Light Brown
	Medium Brown	Dark Brown	Soft Black	Black	Sallow/Yellowed
What is your skin heritage?	Irish/English	Nordic	Russian	Middle-Eastern
	Hispanic	African	Asian	Italian

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:_____
_____
List all surgeries that you have had within the last five years and their approximate dates: _____
_____
_____
Do you have or have you had any other medical condition(s) that your aesthetician should know about?
If yes, please explain: _____
_____
What cosmetic improvements would you like to see in your skin?_____
_____

I have stated all known medical conditions and I will keep the esthetician updated on any changes regarding my health. I claim full responsibility for services rendered. I consent to having "Before" and "After" photographs of said procedure(s) for the purpose of documentation in my file. These photographs **may** _____ or **may not** _____ (please initial one) be used anonymously on our website or in our brochure for advertising purposes.

Signature:_____ Date:_____

Affiliated with Reconstructive & Aesthetic Surgeons, Inc.
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