# The Skin Shop Medspa Scottsdale

**PATIENT INTAKE FORM**

**Name: _____ Date of Birth: _____ Sex:_____**

**Email (Please Print) _____**

**Address: _____ City: _____ State: _____ Zip:_____**

**Home Phone: _____Cell: _____ Work: _____**

**Emergency Contact: _____ Phone: _____**

**May we send text/email reminders:** □Yes □No **May we send text/emails for specials/events:** □Yes □No
**How did you hear about us? (Please check all that apply.)**

**Relative _____ Web Search _____ Google _____Yelp Facebook _____ Instagram** ***Did a current patient refer you? Tell us their name and we will give you and them $25 Referral dollars:***

_____

**SKIN CARE/What is your daily skin care regimen? _____**

**Which of the following best describes your skin type?**

□Combination skin, oily in T-zone, dry to normal cheeks □Oily skin □Very oily skin, large pores
□Sensitive skin □Dry skin

**SUN HISTORY & LIFESTYLE**

How often do you work outdoors? □Frequently □Occasionally □Very Rarely

How often do you use a sunscreen? □Frequently □Occasionally □Very Rarely

How often do you use tanning beds? □Frequently □Occasionally □Very Rarely

**PREVIOUS PROCEDURES:** ***Which of the following have you had in the past?***

**□Botox □Electrolysis □Skin Tightening □Skin Resurfacing**
**□Fillers □Waxing/Threading □Tattoo Removal □Microdermabrasion**
**□Chemical Peels. □Laser Hair Removal. □Skin Rejuvenation □Cellulite/Circumference Reduction**

**INTERESTS :** ***What would you like to learn more about?***

**□ Fine lines/Wrinkles**
**□ Volume Loss/Deep Lines**
**□ Skin Care**
**□ Age Spots/Sun Damage**
**□ Flushing of the Skin**
**□ Acne/Acne Scar Reduction**
**□ Crow's Feet**
**□ Chemical Peels**
**□ Spider Vein Reduction**
**□ Pigmented Lesions**
**□ Large Pores**
**□ Stretch Marks**
**□ Laser Hair Removal**
**□ Skin Texture/Scars**

**Reviewed By: _____Date: _____**