SKYN by V

AT STĀ SOLUTIONS

NEW CLIENT FACIAL INTAKE + CONSENT

Rooted in wellness. Refined by results.

Welcome. Please complete this form before your first facial so your treatment can be safely customized to your skin, goals, current routine, and recent procedures. If anything changes before a future appointment, please let your esthetician know.

01 CLIENT PROFILE

FULL NAME	
PREFERRED NAME	
DATE OF BIRTH	
PRONOUNS (OPTIONAL)	
PHONE	
EMAIL	
EMERGENCY CONTACT + PHONE	
TODAY'S DATE	

HOW DID YOU HEAR ABOUT ME?: _____

02 YOUR SKIN + GOALS *Choose everything that applies*

- ☐ First professional facial
- ☐ Acne / breakouts
- ☐ Blackheads
- ☐ Dryness / dehydration
- ☐ Uneven tone
- ☐ Melasma
- ☐ Fine lines / aging
- ☐ Large / visible pores
- ☐ Scarring / post-acne marks
- ☐ Maintain healthy skin
- ☐ Clogged pores / congestion
- ☐ Excess oil / shine
- ☐ Sensitivity / redness
- ☐ Hyperpigmentation / dark spots
- ☐ Texture / roughness
- ☐ Loss of firmness
- ☐ Dullness / lack of glow
- ☐ Other: _____

WHAT ARE YOUR TOP 3 SKIN GOALS?: _____

_____

IS THERE ANYTHING YOU DO NOT WANT ADDRESSED OR ANYTHING YOU ARE NERVOUS ABOUT?:

_____

03 CURRENT SKIN ROUTINE

- ☐ Cleanser
- ☐ Vitamin C / antioxidant
- ☐ Retinoid / retinol / tretinoin
- ☐ Hydroquinone / pigment corrector
- ☐ Face oil / balm
- ☐ Prescription topical
- ☐ Toner / essence
- ☐ Exfoliating acids (AHA/BHA/PHA)
- ☐ Benzoyl peroxide
- ☐ Moisturizer
- ☐ SPF daily
- ☐ Other

LIST THE PRODUCTS/BRANDS YOU USE MOST OFTEN:

_____

_____

HOW OFTEN DO YOU EXFOLIATE?: _____

SPF BRAND + SPF LEVEL: _____

04 SKIN + HEALTH HISTORY *For treatment safety*

- ☐ No known skin/health concerns relevant to treatment
- ☐ Rosacea / persistent facial redness
- ☐ Psoriasis
- ☐ Cold sores / HSV
- ☐ Recent sunburn / excessive sun exposure
- ☐ Diabetes
- ☐ Seizure / epilepsy history
- ☐ Pregnant
- ☐ Allergy to latex
- ☐ Allergy to skincare ingredients
- ☐ Sensitive or reactive skin
- ☐ Eczema / dermatitis
- ☐ Active acne / cystic acne
- ☐ Open cuts, sores, rash or infection
- ☐ History of keloid or raised scarring
- ☐ Autoimmune condition
- ☐ Cancer treatment / radiation / chemotherapy
- ☐ Nursing / breastfeeding
- ☐ Allergy to aspirin / salicylates
- ☐ Other medical condition that may affect treatment

PLEASE EXPLAIN ANY YES ITEMS, ALLERGIES, OR SENSITIVITIES:

_____

_____

05 MEDICATIONS + ACTIVE INGREDIENTS

- ☐ None
- ☐ Isotretinoin / Accutane - within past 12 months
- ☐ Oral or topical antibiotics
- ☐ Blood-thinning medication
- ☐ Photosensitizing medication
- ☐ Supplements that affect bruising/bleeding
- ☐ Isotretinoin / Accutane - current
- ☐ Prescription retinoid (tretinoin, adapalene, etc.)
- ☐ Steroids
- ☐ Hormonal medication / birth control
- ☐ Other prescription medication
- ☐ Not sure - I would like to review with my esthetician

LIST MEDICATIONS/SUPPLEMENTS AND HOW OFTEN YOU USE THEM:

_____

_____

06 RECENT TREATMENTS + PROCEDURES

☐ None in the past 4 weeks
☐ Chemical peel
☐ Microdermabrasion
☐ Laser / IPL / light-based treatment
☐ Waxing / sugaring / threading on face
☐ Botox / neuromodulator
☐ Permanent makeup / tattooing
☐ Facial / professional exfoliation
☐ Dermaplaning
☐ Microneedling
☐ RF / resurfacing treatment
☐ Facial surgery / stitches / wound healing
☐ Dermal filler
☐ Other

TREATMENT/PROCEDURE + DATE(S): _____

_____

07 LIFESTYLE

☐ Daily SPF
☐ Tanning bed use
☐ Exercise heavily / sweat often
☐ Sleep fewer than 7 hours regularly
☐ Wear makeup most days
☐ Frequent outdoor exposure
☐ Smoke / vape
☐ High-stress lifestyle
☐ Travel often
☐ Pick / extract breakouts at home

ANYTHING ELSE YOU WANT ME TO KNOW ABOUT YOUR SKIN, LIFESTYLE, OR GOALS?:

_____

_____

08 FACIAL TREATMENT CONSENT

☐ **Personalized treatment:** I understand my facial will be customized based on my intake, skin presentation, goals, tolerance, and professional assessment. The treatment may be adjusted, shortened, postponed, or declined if a service is not appropriate for my skin that day.

☐ **Expected skin responses:** I understand temporary redness, warmth, tightness, dryness, sensitivity, flaking, mild swelling, temporary breakouts, or irritation can occur after professional skincare treatments, especially when exfoliating or active products are used.

☐ **Accurate disclosure:** I have disclosed medications, allergies, pregnancy/nursing status, skin conditions, recent procedures, and active products to the best of my knowledge. I agree to update my esthetician if anything changes.

☐ **Aftercare:** I agree to follow aftercare instructions, use sun protection, avoid picking or peeling, and contact my esthetician if I experience an unexpected or concerning reaction.

☐ **No medical diagnosis or guarantee:** I understand esthetic services are cosmetic and wellness-focused, do not diagnose or treat medical disease, and results vary. No specific outcome has been guaranteed.

☐ **Comfort + communication:** I will tell my esthetician immediately if I experience significant burning, pain, dizziness, shortness of breath, or another unexpected symptom during treatment.

By signing below, I confirm I have read and understand the statements above and consent to receive facial/esthetic services from SKYN by V at STĀ Solutions.

09 OPTIONAL PHOTO + MARKETING CONSENT

Treatment documentation: I understand before/after photos may be recommended to track skin progress. Photos used only for my confidential client record do not require public posting permission.

☐ YES - you may photograph me for my private treatment record

☐ NO - I do not want treatment photos taken

Marketing use (optional): Please select one. Declining marketing permission will not affect the care I receive.

☐ YES - I give permission to use approved before/after images for STĀ / SKYN by V education or marketing

☐ YES - only if my face/identity is not recognizable

☐ NO - do not use my images for marketing

10 BOOKING + COMMUNICATION ACKNOWLEDGMENT

☐ I agree to the booking, cancellation, late-arrival, and no-show policy presented at the time of booking.

☐ I consent to appointment-related calls/texts/emails about scheduling, reminders, aftercare, or treatment follow-up.

11 SIGNATURE

CLIENT SIGNATURE	DATE
PRINTED NAME	DATE OF BIRTH
PARENT/GUARDIAN SIGNATURE (IF REQUIRED)	RELATIONSHIP

FOR ESTHETICIAN USE ONLY

SKIN PRESENTATION / TYPE	CONTRAINDICATIONS / MODIFICATIONS
TREATMENT PERFORMED	KEY PRODUCTS / MODALITIES USED
HOME-CARE RECOMMENDATIONS	NEXT APPOINTMENT / TREATMENT PLAN