

Intake Form

Thank you for your interest in Aesthetics at Ducharme Dermatology, PC!

Demographic information

_____	_____	_____	_____
<i>Full Name</i>	<i>Date of Birth</i>	<i>Age</i>	<i>Gender</i>
_____	_____		
<i>Street Address</i>	<i>City, State & Zip Code</i>		
_____	_____		
<i>Email Address</i>	<i>Cell Phone Number</i>		
_____	_____		
<i>Emergency Contact Name</i>	<i>Emergency Contact Phone Number</i>		

Please take a moment to answer the following questions:

1. What is your main concern today that brings you in to our clinic?

Answer: _____

2. Are there any specific products or services you are interested in learning about today?

Answer: _____

3. Do you have any other concerns? (please check boxes)

<input type="checkbox"/> Fine lines or wrinkles	<input type="checkbox"/> Stretch marks	<input type="checkbox"/> Erectile dysfunction
<input type="checkbox"/> Acne or acne scarring	<input type="checkbox"/> Excess bodyfat	<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Core strength or balance	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dull skin	<input type="checkbox"/> Sexual health	

4. Have you ever had any of the following treatments? (please check boxes)

<input type="checkbox"/> Facial	<input type="checkbox"/> Laser skin resurfacing	<input type="checkbox"/> Tummy tuck or liposuction
<input type="checkbox"/> Hydrafacial or DiamondGlow	<input type="checkbox"/> Body contouring	<input type="checkbox"/> Face lift
<input type="checkbox"/> The SaltFacial	<input type="checkbox"/> Toxin injections (e.g. Botox)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Chemical peels	<input type="checkbox"/> Filler injections	

Were you happy with the outcome(s)? Yes No N/A

If "No", please explain: _____

5. How much do you exercise each week?

Cardio _____ hrs Strength _____ hrs

Are you happy with your fitness level? Yes No

6. What skincare products do you use?

Answer: _____

7. How did you hear about us?

Answer: _____

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8. Are you currently under a physician's care for any condition or problem? Yes No

If "Yes", please list: _____

9. Do you have any allergies? Yes No

If "Yes", please list: _____

10. Have you ever taken isotretinoin (Accutane)? Yes No

If "Yes", when did you last take it? _____

11. Are you currently on any other medications? Yes No

If "Yes", please list: _____

12. Please indicate if any of the following apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Drug pumps | <input type="checkbox"/> Malignant cancer |
| <input type="checkbox"/> Have given birth | <input type="checkbox"/> Electronic implants | <input type="checkbox"/> Active hernia |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Metallic implants | <input type="checkbox"/> Any surgeries |
| <input type="checkbox"/> Implanted defibrillator | <input type="checkbox"/> Metallic IUD | <input type="checkbox"/> Any skin disease/sensitivity |
| <input type="checkbox"/> Implanted neurostimulator | <input type="checkbox"/> Epilepsy | |

If any checked, please explain: _____

13. Is there anything else about your health history that we should know about?

I understand that the services offered are not a substitute for medical care; and any information provided by the therapist, is for the educational purposes only and not diagnostically prescriptive in nature. I understand that the information above is to aid the therapist in giving a better service and is completely confidential.

Email marketing: By providing my email address, I understand that I am opting in for email marketing from Ducharme Dermatology, PC and affiliates. I may opt out at any time by emailing info@iowaskin.com.

Pictures: By signing below, I understand that I am consenting to let Ducharme Dermatology, PC take pictures of my treatments that may be used for evaluation and marketing purposes.

Cancellations: We request a minimum of 24 hours notice for cancellations of any scheduled appointments, otherwise there will be an overhead fee if a no call no show.

Client Signature: _____ **Date:** _____