Heart Mind Body
HEALTH & WELLNESS

SKIN HEALTH CLINIC

Patient Intake Form

Confidential Patient Information

Name _____ Date _____

Phone: Res _____ Bus _____ Cell _____

Email _____

Address _____ City _____ Postal Code _____

Date of Birth (M/D/Y) _____ Single ☐ Married ☐ Common Law ☐ Div ☐ Sep ☐ Widow/er ☐

N° of Children _____ Family Physician _____

Occupation _____ N° of Years _____ Employer _____

Health Card N° _____ Version Code _____

Who may we thank for referring you to our office? _____

Health Profile

Please answer the following questions by indicating yes (Y) or no (N)

Y ☐ / N ☐ Do you have a pacemaker or cardiac irregularities?

Y ☐ / N ☐ Do you bruise easily or take any blood thinner medications?

Y ☐ / N ☐ Do you have a history of any neuro-muscular disorders?

Y ☐ / N ☐ Are you currently pregnant, planning pregnancy, or breast feeding?

Y ☐ / N ☐ Are you epileptic or suffer from migraines?

Y ☐ / N ☐ Are you diabetic or do you follow a specific diet or menu plan?

Y ☐ / N ☐ Do you currently smoke or do you consumer alcohol on a daily basis?

Y ☐ / N ☐ Do you ever use tanning beds?

Y ☐ / N ☐ Do you every forget to apply sunscreen in the morning?

Y ☐ / N ☐ Do you get less than 8 hours of quality sleep each night?

Y ☐ / N ☐ Do you have any Sinus/Rhinitis problems or problems breathing through your nose? (this may make you more likely to experience inflammatory reactions to injectable fillers)

Y ☐ / N ☐ Do you have previously diagnosed medical problems, skin diseases, cold sores, or family history of skin cancer?
If yes, please specify _____

Y ☐ / N ☐ Have you had any previous facial surgery, plates, screws, implants, excessive metal fillings, dental retainers, hearing implants?
If yes, please specify _____

Y ☐ / N ☐ Do you have any other medical history or medical concerns/ailments currently being investigated?
If yes, please specify _____

Y ☐ / N ☐ Do you have any know allergies, rashes or sensitivities (i.e. drugs, vitamins, environmental, cosmetic, topical anesthetic, etc.)?
If yes, please specify _____

Y ☐ / N ☐ Do you use/take any medications, Accutane and/or vitamin or mineral supplements?
If yes, please specify name and reason for use _____

Skin Treatment Profile

Please list your main skin health concerns/goals

1) _____

2) _____

3) _____

On a scale of 1-10 (10 being highest), how committed are you to incorporating a skin care treatment plan into your health & wellness regime?

1 2 3 4 5 6 7 8 9 10

From the following please indicated any prior skin treatments, and products your are currently using.

PREVIOUS Other in Clinic Treatments		
	Comments	**Date**
Botox (neuromodulator)		
Filler		
Vitamin Infusion Therapy		
Body Contouring		
Surgical Enhancements		
Skin Regeneration Procedures		
Skin Resurfacing (peels, microdermabrasion)		
Other		

Current at Home Treatments		
	Comments	**Date**
Cleanse (exfoliates, soaps, etc.)		
Tone (toner, etc.)		
Target (wrinkle serum, eye cream, colour correction, acne treatment, etc.)		
Nourish (moisturizer, topical vitamin treatment)		
Protect (sunscreen/SPF)		
Other		

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contact@heartmindbody.ca

Personal Skin Assessment & Overview

Using the following lists, please provide a rating for your concern on a scale of 1-4 (4 being very concerned).
Anything that is not a concern, please leave blank.

Cosmetic

Please identify all conditions/concerns that have affected your skin and the location(s) of the conditions by writing the corresponding letter on the body area lines provided.

Body Area Location Key

A – Forehead
B – Under Eye Area
C – Below Eye Area
D – Jawline
E – Lips
F – Neck
G – Back
H – Buttocks
I – Stomach
J – Thighs
K – Other

Conditions	Body Area(s)	Scale of Concern
Fine lines	___ ___ ___ ___	1 2 3 4
Dryness	___ ___ ___ ___	1 2 3 4
Dullness	___ ___ ___ ___	1 2 3 4
Oiliness	___ ___ ___ ___	1 2 3 4
Pores	___ ___ ___ ___	1 2 3 4
Sensitivity	___ ___ ___ ___	1 2 3 4
Blood Vessels	___ ___ ___ ___	1 2 3 4
Dark Spots	___ ___ ___ ___	1 2 3 4
Redness	___ ___ ___ ___	1 2 3 4
Rough Patches	___ ___ ___ ___	1 2 3 4
Blemishes	___ ___ ___ ___	1 2 3 4

Structural

Conditions	Scale of Concern
Cellulite	1___ 2___ 3___ 4___
Lax skin	1___ 2___ 3___ 4___
Scars	1 2 3 4___
Stretch marks	1 2 3 4
Uneven texture	1 2 3 4
Nasal labial folds	1 2 3 4
Marionette lines	1 2 3 4
Crows feet	1 2 3 4
Sagging jaw	1 2 3 4
Lips	1 2 3 4
Forehead lines	1 2 3 4
Frown lines	1 2 3 4

Disease

Conditions	Scale of Concern
Acne	1___ 2___ 3___ 4___
Eczema	1___ 2___ 3___ 4___
Cold sores	1___ 2___ 3___ 4___
Psoriasis	1 2 3 4
Cancer	1 2 3 4
Other (diagnosed by a physician)	1 2 3 4

Clinical Notes (office only):

_____

_____

_____

_____

Other Concerns

Conditions	Scale of Concern
_____	1 2 3 4
_____	1 2 3 4
_____	1 2 3 4
_____	1 2 3 4
_____	1 2 3 4
_____	1___ 2___ 3___ 4___

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Heart Mind Body Professional Disclosure and Consent

Possible effects during or after treatments with DF Ionzyme Machine and / or Environ Peel:

You might experience and of the following during treatment:

- Slight flashing over the eyes
- Tingling sensation in the area that the passive pad / electrode is placed
- Tingling sensation on the skin
- A high pitched sound when the sonophoresis probe is applied to the forehead, close to the ears and nasal cavities
- You could experience a retinoid reaction (flaking, dryness, skin sensitivity or slight breakouts)
- Dryness and flaking are the desired results of a peel and this is transient

Possible effects during or after treatments with Medical Collagen Induction Therapy (Needling):

As Medical Needling does not cause open wounds, there are usually no complications or unwanted side effects. All the same, we would still like to inform you about the the following risks:

- Wound infection can occur any time we operate on the skin but it is extremely unlikely after needling and if it were to happen it can easily be treated with antibiotics
- Brusining can sometimes be more than expected
- Temporary skin numbness from topical anesthetic
- Scarring is always a possible complication of any procedure done to the skin if it becomes infected
- Skin pain is transient and usually very mild
- Eye injury would only happen if the rollers or stamping devices were accidentally used on the eye itself
- Postoperative herpes simplex is a possibility, but uncommon, in patients who are prone to herpes. It is not necessary to use pre-emptive treatment but rather treat symptoms as they occur. The patient may use l-Lysine before the treatment if they prefer
- Cardiovascular problems (problems of the heart and circulation) have been described when using excessive doses of topical anesthetic and for that reason we cannot treat large areas e.g. both legs at the same session

Contraindications:

- If you have skin cancer or pre-cancerous lesions
- Iontophoresis: excess metal fillings, dental work, pace maker, hearing implant
- Active skin infections, skin cancers, warts, solar keratosis, ear infection
- Pregnancy
- Anti-coagulant therapies require a doctor's consent to proceed with Medical CIT
- Known allergies to the topical anesthetic
- Cis-retinoic acid (e.g. Roaccutane) – allow 6 months after completion of treatment to avoid any potential healing problems.
- Botox – allow 10 days after injected
- Fillers – allow 14 days after injected

I confirm that the proposed treatments and products to be used on my skin have been fully explained to me. I am aware the no warranty or guarantee is given regarding the result of any treatment or the products used in such treatment.

I hereby warrant that the information provided by me and recorded in my "client file" is true and correct, and I understand that the non-disclosure by me of material information or the disclosure of misinformation concerning any matter pertaining to my health or skin condition may have adverse consequences for which the SkinHealth Clinic will not be responsible.

_____

Name (Please Print)

_____ Date: _____ 20 _____

Signature of patient

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SUBMIT