Medical & Therapeutic Aesthetics

Intake Form

Personal Information

FULL NAME: DATE:

D.O.B. AGE: PHONE:

ADDRESS: EMAIL:

In order to perform medical aesthetic treatments in a safe manner, please answer the following health questions truthfully. Chapala Health & Aesthetics, LLC will keep all information disclosed in a confidential manner and will use it only for purposes of determining whether you are an ideal candidate for this procedure. This form is completely confidential. Completion of form gives the general state of health and assists Dr. Chapalamadugu in directing a customized course of treatment for you.

Have you ever had a cosmetic neurotoxin (Botox®, Xeomin®, Dysport®, Jeuveau®) or therapeutic Botox ® treatment, dermal fillers, microneedling, AquaGold, lipolysis (Kybella, CoolSculpting or laser), face or neck contouring or trigger point injection?

If yes, please list: ____________________

If yes, when were you last treated: ____________________

Any complications?____________________

If you have had treatments in the past, which one(s) do you feel work best for you?____________________

Please list any allergies to food or medication:____________________

____

Have you ever had an allergic reaction to: ☐ Yes ☐ No

- Lidocaine, Tetracaine, or Benzocaine ☐ Yes ☐ No
- Calcium Hydroxylapatite ☐ Yes ☐ No
- Animal Protein ☐ Yes ☐ No
- Hydroquinone or skin bleaching agents ☐ Yes ☐ No
- Eggs ☐ Yes ☐ No
- Neurotoxin ☐ Yes ☐ No
- Hyaluronic Acid ☐ Yes ☐ No

*Are you currently pregnant? ☐ Yes ☐ No

*Are you breastfeeding? ☐ Yes ☐ No

PLEASE CIRCLE OR HIGHLIGHT IF ANY OF THE FOLLOWING APPLY TO YOU:

Skin Infection
Autoimmune Disease
Cancer
Diabetes
Herpes
Frequent Cold Sores
Keloid Scarring
Eye Disease
Excessive Sweating
Muscle Spasms

Neuromuscular disorder
Seizure disorder
Multiple Sclerosis
Migraines
Thyroid imbalance
Bleeding disorder/ Blood clotting abnormalities/ Platelet Disorders
Heart arrhythmias
High blood pressure
Hormone imbalance
Immunocompromised

Are you presently taking or taken any of the following medication or supplements listed below in the past 2 weeks?

Aspirin
Vitamin E
Fish Oil
Immunosuppressants
Blood thinners
Ginkgo biloba
COQ10
Other medications:
____

Omega 3 fatty acids
Aspirin
Hormones
Glaucoma or medicated eye drops
Mood altering medication
Anti-depression medication
Steroids (prednisone)

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Answer the following questions if applicable:

What are your expectations for today's visit?____

Have you had a chemical peel, facial, laser or microdermabrasion within the last week?________________________

What topical medications or creams are you currently using?____ _

Have you waxed, tweezed, bleached or used hair removal cream within the last week?_____________

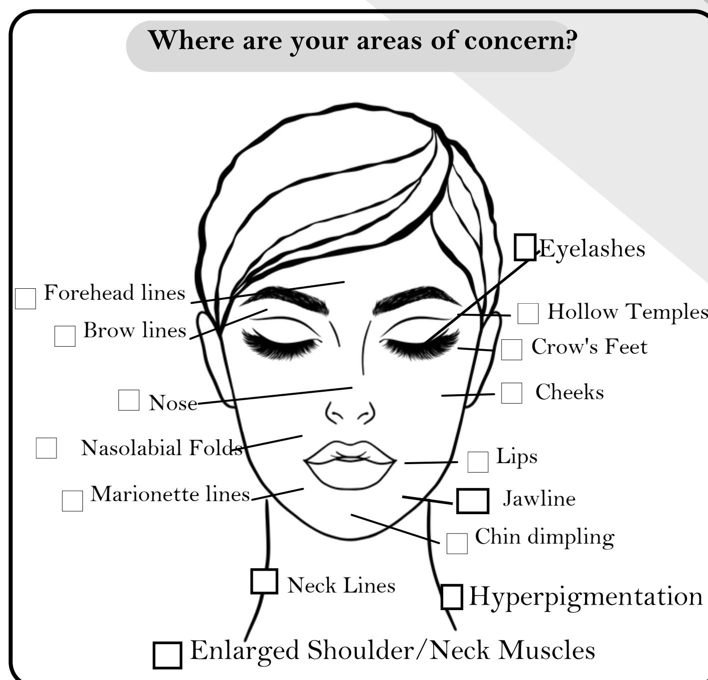
If Applicable:

What treatments have you used/still use for migraines? ______________________________

Which migraine treatments were/are effective?___________________________________

What treatments have you tried/still use for hyperhidrosis?_________________________________

Which treatments were/are effective? _______________________________________



Facial Injury/Trauma History:

Do you have any history of facial or eye surgery?

☐ Yes ☐ No

Please describe

Is there any recent history of trauma to the head or face?

☐ Yes ☐ No

Please describe

Are you experiencing TMJ problems?

☐ Pain ☐ Clenching ☐ Grinding

Any prior TMJ treatment?

Are you experiencing muscle spasm pain? ☐ Yes ☐ No

If so, where?________________________

Are you bothered by areas where you can pinch fat? ☐ Yes ☐ No

If so, where?___________________________________

What is your tolerance to pain (injections, shots, needles):

☐ I can't handle it ☐ I have some discomfort, but it's manageable ☐ No worries!

I have completed this form to the best of my ability and knowledge and agree to inform Dr. Chapalamadugu if any of the above information changes at any time.

Printed Client Name:___________________________________ Date:_________

Client Signature:______________________________________