



LOTUS PROFESSIONAL COLLEGE

Lotus Professional College

Esthetics Volunteer Intake Form

CONFIDENTIAL VOLUNTEER HEALTH HISTORY

Today's Date _____

Name _____

Gender _____

Address _____

Date of Birth _____

City _____

State _____ Zip _____

Phone # (primary) _____ (secondary) _____

Occupation _____ Email _____

How did you hear about our school? _____

Emergency Contact Name _____ Phone # _____

Relationship _____ Email _____

FACIAL EXPERIENCE

Previous Experience with facial treatments _____

What did you like/dislike about your experience? _____

Areas to avoid _____

Areas of sensitivity _____

Preferred level of pressure (please check one) _____ Light _____ Moderate _____ Firm

HEALTH CARE INFORMATION

1. Are you under the care of a physician, dermatologist or other medical professional? _____ Yes _____ No

If yes, for what conditions? _____

2. Any recent surgery, including plastic surgery, Botox or Fillers? _____ Yes _____ No

If yes, please list and how recent: _____

3. Any skin cancer? _____ Yes _____ No

If yes, please explain: _____

4. Have you had any piercings, tattoos, permanent cosmetics? _____ Yes _____ No

If yes, where: _____

5. Do you smoke? _____ Yes _____ No Do you drink alcohol _____ Yes _____ No Do you exercise? _____ Yes _____ No

If yes, frequency: _____

6. List any medications you take regularly:

7. List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

Do you experience now, or have you been diagnosed with, any of the following conditions or pains? (please check all that apply)

Headaches	Allergies (skin/seasonal)	Arthritis (osteo, rheumatoid)
Hormone imbalance	Psychological treatment	Lupus
Edema	High/Low Blood Pressure	frequent cold sores
Systemic disease	Asthma	Eczema
Osteoporosis	HIV/AIDS	Epilepsy/Seizures
Varicose Veins	Insomnia	Neck/Shoulder Injuries
Spinal injury	Keloid scarring	Contagious Disease
Flu/Cold/Fever	Hepatitis	Menopause
Diabetes	Herpes	Pregnancy
Thyroid condition	Depression/Anxiety	Fever Blister
Heart Disease	Cancer	Immune disorders
Hysterectomy	Skin Disorders	Contagious disease/Active infection
Other:		

9. Has your physician discussed concerns about raising your body temperature? Yes No

If yes, explain why: _____

10. Do you use Retin-A, Renova, Adapalene, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol? Yes No

If yes, please list: _____

8. Have you used any of these products in the last 3 months? Yes No

If yes, please list: _____

9. Are you currently using any acne medication? Yes No

If yes, which medication and last used: _____

10. Do you form thick or raised scars from cuts or burns? Yes No

If yes, please describe: _____

11. Do you wear contact lenses? Yes No

If yes, are you comfortable removing them: _____

12. Have you been exposed to the sun or used a tanning bed in the last 48 hours? Yes No

If yes, how long was the exposure: _____

13. Do you have any metal implants or a pacemaker? Yes No

If yes, please specify: _____

14. Have you ever had an adverse reaction after using any skin care product? Yes No

If yes, which product and what kind of reaction: _____

18. Have you ever had an allergic reaction to any of the following? (Circle all that apply) Yes No

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: _____

Female Volunteers Only (questions 19-22):

- 19) Are you taking oral contraceptives? ___ Yes ___ No
- 20) Are you pregnant or trying to become pregnant? ___ Yes ___ No
- 21) Are you lactating? ___ Yes ___ No
- 22) Any menopause problems? ___ Yes ___ No

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

* * * * *

I, agree to be a client volunteer and understand that this practice esthetics session is free of charge. I understand there will be a nominal school administration fee. A 24-hour notice is required if I need to cancel or reschedule my appointment. If I do not provide the required notice, I am responsible to pay 50% of the administrative fee prior to scheduling any future appointments. This practice session is intended to be a learning experience for the student. I agree not to hold the student, responsible for anything that occurs as a result of this esthetics session. It is my responsibility to let the student know if the esthetics techniques being used during the session causes discomfort in any way.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the student / teacher of my current medical or health conditions and to update this history. I understand that receiving esthetic treatments could cause bleeding, bruising, and/or scarring. The treatments I receive here are voluntary and I release the Lotus Professional College, faculty and students from liability and assume full responsibility thereof.

We appreciate all that the client volunteers do for the school. Our LPC Practicum Clinic would not be possible without your continued patronage.

If volunteer is a minor under 16 years of age, parent or guardian must be present for consultation and treatment.

If volunteer is a minor between 16 and 18 years of age, parent or guardian must be present for consultation and is encouraged to say during the treatment.

Volunteer Signature: _____ Date: ___/___/___

Parent/Legal Guardian: _____ Date: ___/___/___

**Required if client under 18 years of age*

Volunteer Name: _____

I hereby consent to and authorize _____ to perform the following procedure:

Student Name

Treatment/Procedure: _____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards.

Date: ____/____/____

Client Initials _____

I hereby consent to and authorize _____ to perform the following procedure:

Student Name

Treatment/Procedure: _____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards.

Date: ____/____/____

Client Initials _____

I hereby consent to and authorize _____ to perform the following procedure:

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Client Initials _____
