Oncology Esthetics
Consent/Intake Form

Name: _____Date:_____

Address: _____City_____Zip:_____

Email address: _____Date of Birth_____/_____/_____

Phone: (_____) _____-_____ Referred by: _____

Emergency Contact name _____Phone: (_____) _____ - _____

Doctor's Name _____ Phone: (_____) _____ - _____

SKIN:
Are you experiencing any skin issues? _____YES _____NO If yes, explain_____

_____

SCALP:
Are you experiencing any scalp issues? _____YES _____ NO If yes, explain_____

_____

Are you experiencing any hair loss? _____YES _____ NO Do you wear a wig? YES _____ NO _____

NAILS:
Are you experiencing any nail (finger or toe) issues? _____YES _____NO If yes, explain _____

_____

MEDICATIONS:

*Chemotherapy? _____YES ____NO Date started Chemo _____

Name of Chemotherapy drug and all other
medications_____

_____

LIST CURRENT SKIN CARE PRODUCTS THAT YOU USE: _____

_____

_____

ALLERGIES:

Please list all known allergies _____ _____

_____

PLEASE ANSWER THE FOLLOWING:

* Type of Cancer _____ Date Diagnosed_____

* _____YES _____NO **Surgery** If yes, date/s _____

* _____YES _____NO **Incision Site** If yes, location_____

* _____YES _____NO **Port, PICC, Ommaya or Central Line**. If yes, location_____

* _____YES _____NO **Radiation Therapy** If yes, dates of last treatment _____

* _____YES _____NO **Lymph Nodes removed**. If yes, # of Lymph Nodes removed _____

* _____YES _____NO **Lymphedema.** If yes, location/side: _____

* _____YES _____NO **Swelling, Pain, Inflammation, Burning** . If yes, location: _____

* _____YES _____NO **Radiation Burns**. If yes, location: _____

* _____YES _____NO **Poor wound healing**. If yes, explain: _____

* _____YES _____NO **Hypersensitivity or Irritation.** If yes, explain:__ _____

* _____YES _____NO **Dryness.** If yes, explain: _____

* _____YES _____NO **Rashes.** If yes, explain: _____

* _____YES _____NO **Peripheral Neuropathy.** If yes, explain: _____

* _____YES _____NO **Hand/Foot Syndrome (PPE).** If yes, explain: _____

*_____YES _____NO **Fatigue .** If yes, explain: _____

*_____YES _____NO **Shortness of breath.** If yes, explain: _____

*_____YES _____NO **Chills or Loss of balance**. If yes, explain: _____

*_____YES_____NO **Claustrophobia**. If yes, explain:_____

* I acknowledge that all the information provided by me is true and correct to the best of my knowledge and that I **must wait 48 hours after a Chemotherapy infusion** prior to having a skin care treatment.

I also understand that due to my medical history, cancer therapy and medications, that some skin conditions may require more than one treatment to achieve the desired results.

I understand that in order to achieve certain results, I will need to discontinue the use of home care products containing ingredients that are too strong, aggressive or drying at this time. (These will be discussed with you by your Esthetician).

Signature _____ Date: ____/____/____

Esthetician Signature _____ Date: ____/____/____