

# THE SPA AT DAYTONA COLLEGE

## Cosmetology Intake Form

Student Name: \_\_\_\_\_

Clinic Number: \_\_\_\_\_

PERSONAL DATA			
Name		Date	
Address		Phone (day)	
City/State/Zip		Phone (eve)	
Birth Date		Occupation	
Emergency Contact		Cell phone	

YES	NO	Please Answer The Following Questions
		Do you have a chemical service currently in your hair and if so please describe:
		Have you ever been here before? If yes, what was the last service & when was it?
		Do you have any medical challenges we need to be concerned about?
		How do you like to style your hair? What do you like most and least?
		Are you currently taking any medications? If yes, which ones?
		Describe any concerns you may have had in the past in reference to a nail service:

What are the reason(s) for your visit today?

What special areas of concern do you have?

Please Check The Conditions You've Experienced/ Star (*) If Have Occurred In The Last 2 Years					
	Accident		Eating Disorder		Immune Disorders
	Alopecia (hair loss)		Eczema		Low Blood Pressure
	Allergies		Fungus (nail disorder)		Thyroid medications
	Anxiety		Fever Blisters		Metal Pins, Screws, or Plates
	Arthritis		Headaches – chronic		Pacemaker
	Asthma		Head Injuries		Rashes
	Blood Clots		Heart Condition		Sinus Problems
	Cancer/Tumors		Hepatitis		Stroke
	Claustrophobia		Scalp disorders		Surgeries
	Depression		High Blood Pressure		TMJ/Jaw Pain
	Digestive System Issues		Hysterectomy		OTHER:
	Diabetes		Infections		OTHER:

Thank you for your time and we hope you have a pleasant experience at Daytona College!

I understand that \_\_\_\_\_ is a student at Daytona College & that I am assisting him/her in a Cosmetology Service for the sole purpose of completing required clinical theory and practice. I understand that there are students of varying degrees of competency enrolled in the program: Some are seniors, preparing to graduate, and others are recently enrolled in the program. All are skilled and competent with the techniques employed today at the clinic.

I hereby agree & acknowledge that this clinic service shall not be considered a professional service & that the student shall not be considered a licensed professional.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CLIENT'S IMPRESSIONS & COMMENTS**

YES	NO	PLEASE PLACE AN X IN THE APPROPRIATE BOX
		Were you greeted pleasantly?
		Were you told what to do and explained what was going to take place?
		Were you satisfied with your session?
		Was there anything that made you uncomfortable?
		Did you feel your technician/stylist listened to you?
		Did you feel that your technician/stylist was properly skilled and confident?
		Would you receive another professional service from this technician/stylist?

Circle how well you feel the student addressed your specific needs? Poor Fair Good Excellent

General Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**INFORMATION BELOW TO BE FILLED OUT BY THE STUDENT ONLY**

Student's Comments and service

record: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_