CONTOUR
by Joplin ENT

TOX

Client Intake Form

CLIENT INFORMATION

Full Name: _____ Date of Birth: _____
Phone Number: _____ Email Address: _____
Address: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____

MEDICAL HISTORY

Please check all that apply:

[ ] Pregnant or nursing
[ ] Autoimmune disorders
[ ] History of keloid scarring
[ ] Allergies to lidocaine or other anesthetics
[ ] Previous neurotoxin (date: _____)
[ ] Cold sores or herpes simplex
[ ] Diabetes
[ ] Bleeding disorders
[ ] Use of blood thinners

If any checked, please explain:

_____

SOCIAL HSITORY

_____

Do you smoke? [ ] Yes [ ] No Do you drink alcohol? [ ] Yes [ ] No

TREATMENT GOALS

What areas are you interested in treating?

[ ] Frown Lines
[ ] Forehead Lines
[ ] Crow's Feet
[ ] Eyebrow Lift
[ ] Bunny Lines
[ ] Gummy Smile
[ ] Other: _____

What are your expectations from this treatment?

_____

CONSENT & ACKNOWLEDGEMENT

By signing below, I confirm that:

- I have answered all questions truthfully and to the best of my knowledge.
- I understand the nature, risks, and possible side effects of neurotoxin treatment.

I give consent to receive the procedure and for my information to be used for treatment purposes.

Client Signature: **Provider Signature:**
Date: **Date:**