Skin Care Consultation Form

Date: _____

Name: _____Date of Birth: _____

Address: -_____

Home Phone: _____Business Phone: _____

Cell Phone: _____ E-mail address: _____

Single: No Yes Married: No Yes If yes, anniversary date: _____

Employer: _____ Occupation: _____

Does your job require that you work outdoors? No Yes

Referred by:

_____

What would you like to achieve from your treatment today?

_____

Your Skin Care

1) Have you ever had a facial treatment before? No Yes, when? _____

2) Which of the following best describes your skin type? (Please circle one type number)

I. Creamy complexion Always burns easily, never tans II. Light Complexion Always burns, tans slightly III. Light/Matte Complexion Burns moderately, tans gradually IV. Matte Complexion Seldom burns, always tans well V. Brown Complexion Rarely burns, deep tan VI. Black Complexion Never burns, deeply pigmented

3) Do you have any special skin problems or concerns pertaining to your face or body? Yes No

Please specify: _____

4) Have you ever had chemical peels, laser or microdermabrasion? No Yes In the last month? No Yes

5) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? No Yes

Please describe: _____

6) Have you used any of these products in the last 3 months? No Yes

7) Have you used an acne medication? No Yes, when? _____ Which drug? _____

8) What skin care products are you currently using? (List brand where known)

9) Have you recently used any self-tanning lotions, creams or treatments? No Yes

Please specify:_____

10) Have you used any of the following hair removal methods in the past six weeks? No Yes, circle all that apply. Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

11) What areas of concern do you have regarding your: Skin: (Please circle any that apply and explain)

Eyes: dehydrated, wrinkles, puffiness, dark circles, Other: _____ Lips: dehydrated, cracked/chapped lips, Other: _____

12) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain) If yes, please explain: _____

Soap ____Toner ____Mask_____ Eye Product ___Cleanser____ Day Moisturizer_____ Exfoliator ____Scrubs _____Shower Gels ____Body Lotions____ Sunscreen _____SPF____ Night Moisturizer/Cream ____Other _____

Makeup Products _____

Circle all that apply:

Breakouts/acne Blackheads/whiteheads Excessive oil/shine Rosacea Broken capillaries Redness/ruddiness Sun spot/liver spot/brown spot Uneven skin tone Sun damage Wrinkles/fine lines Dull/dry skin Flaky skin Dehydrated
Other_____

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen

AHAs Fragrance Shellfish Latex Drugs Other_____

13) What SPF do you use on your face? _____ How often/when? _____

14) What SPF do you use on your body? _____ How often/when? _____

15) Have you had any recent tanning bed or sun exposure that changed the color of your skin? No Yes

Please specify: _____

17) Have you experienced Botox, Restylane or Collagen injections? No Yes

Please specify:
_____

Female Clients Only: 18) Are you taking oral contraceptives? No Yes

Please specify:_____

18) Any recent changes to or from your contraceptive treatment? No Yes

If so, what and when: _____

19) Are you pregnant or trying to become pregnant? No Yes

20) Are you lactating? No Yes

22) Any menopause problems? No Yes

Please specify: _____

23) Are you undergoing any hormone replacement therapy? No Yes

Please specify:_____

Male Clients Only:

23) What is your current shaving system? Wet shave Electric

24) Do you experience irritation from shaving? No Yes Ingrown hairs? No Yes

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

_____
_____
_____
_____

Future Appointments/Contact:

May I call you at your home, work or cell phone number to confirm future appointments? No Yes May I contact you via mail/email about future promotions and news? No Yes

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. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____

Date:_____