

Client Intake/Consultation

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

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

In case of emergency: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Okay to e-mail?  yes;  no

Your Skin Goals and Concerns: \_\_\_\_\_

Your Skin Type:  Normal/Combo

Oily

Sensitive

Dry

Mild Acne

Mature and Aging

Moderate Acne

What skin products are you currently using? \_\_\_\_\_

What makeup products are you currently using? \_\_\_\_\_

Does your job and lifestyle require that you work/play outdoors? \_\_\_\_\_

Do you wax your facial skin on a regular basis? Yes No If so, when was the last time? \_\_\_\_\_

Have you ever had facials, chemical peels, microdermabrasion or any resurfacing treatments?  Yes  No  
If yes, was it within the last month?  Yes  No

Are you using? Retin-A  Yes  No; Are you using Benzoyl Peroxide?  Yes  No

Tell me about any allergies or sensitiveness you have: \_\_\_\_\_

Have you ever experienced a reaction to any of the following?  cosmetics;  medicine;  iodine (shellfish);  latex;  pollen;  food or fruit;  animals;  fragrance;  alpha hydroxy acids;  sunscreens.

Tell me about any health issues you have: \_\_\_\_\_

Cancer?  Yes  No

Chemotherapy?  Yes  No

Circulatory issues?  Yes  No

High blood pressure?  Yes  No

Arthritis?  Yes  No

Hysterectomy?  Yes  No

Hormonal imbalances?  Yes  No

Thyroid?  Yes  No

Diabetes?  Yes  No

Pregnant? Or about to become pregnant?  Yes  No

Lactating?  Yes  No

Recent surgeries?  Yes  No

Psoriasis?  Yes  No

Eczema?  Yes  No

Tell me about any medications you take: \_\_\_\_\_

Accutane?  Yes  No; Antibiotics?  Yes  No; Birth Control?  Yes  No

I have read and completed this questionnaire truthfully. 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 are voluntary and I release the company and/or skin care professional from liability.

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