Client Intake & Consultation

Name: ____ **Date of Birth:** ______/______/______

Address: ____

Telephone: (______)____________________ **E-Mail:** ____ Okay to e-mail? Yes No

Emergency Contact: ____ **Telephone:** (______)___________________

Your Skin Goals and Concerns: ____

____

____

Your Skin Type: Normal/Combo Oily Sensitive Dry Mild Acne Moderate Acne Mature & Aging

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 yes, 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

Do you have any allergies or sensitivities? ____

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

Do you have any of the below health issues?:

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?	Yes No
Lactating?	Yes No	Planning to be pregnant?	Yes No
Psoriasis?	Yes No	Recent surgeries?	Yes No
Cold Sores?	Yes No	Eczema?	Yes No

Do you take any medications? ____
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: __________________________