

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: _____

