Client Intake & Consultation

Name: _____ **Date of Birth:** _____/_____/_____

Address: _____

Phone: (_____)_____ **E-Mail:** _____ Okay to e-mail? ☐ Yes ☐ No

Emergency Contact: _____ **Phone:** (_____)_____

About You:

Do you Consider your Skin (Circle best option): Sensitive/Resilient/Unsure?

Describe your Skin: ☐ Normal ☐ Combo ☐ Oily ☐ Sensitive ☐ Dry ☐ Mild Acne ☐ Moderate Acne ☐ Mature & Aging

What are the changes you'd most like to see in your skin? _____

_____

_____

What skin products are you currently using? _____

_____

_____

What makeup products are you currently using? _____

_____

Are you pregnant or lactating? ☐ Yes ☐ No

Planning to be pregnant? ☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Do you Currently have a sunburned/windburned/red face? ☐ Yes ☐ No
Why? _____

Are you in the habit of going to tanning booths? ☐ Yes ☐ No

Do you participate in vigorous aerobic activity or sports?
What type? _____

Do you smoke or use tobacco? ☐ Yes ☐ No

What kind of work do you do? _____

On average, how many hours per week do you spend outdoors? _____

Medical/Treatment History:

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 or facial surgery? ☐ Yes ☐ No
If yes, was it within the last month? ☐ Yes ☐ No

What type/when? _____

Do you have regular collagen, Botox, or other dermal filler injections? ☐ Yes ☐ No

Are you currently taking any medications, topical or other wise? ☐ Yes ☐ No
*Retin-A/Renova (Tertinoin), Differin (Adapalane), Tazorac/Avage (Tazatortene), Epiduo (adapalene & Benzoyl Peroxide), Ziana (Tertinoin & Clyndamycin)

Which one(s)? _____
For how long? _____
What Strength? _____
(High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

Other medications? _____

Have you ever undergone Accutane Therapy (isotretinoin)? ☐ Yes ☐ No

Do you develop cold sores/fever blisters?
Last breakout? _____

Do you have any allergies or sensitivities? ☐ Yes ☐ No
☐milk ☐apples ☐citrus ☐ grapes ☐aloe vera ☐aspirin ☐fragrances ☐latex ☐hydroquinone ☐mushrooms ☐sunscreens ☐pollen ☐medicines ☐iodine(shellfish) ☐alhpa hydroxy acids

If any other allergies, what? _____

Have you Ever used any other products that caused a bad reaction? ☐ Yes ☐ No
Describe _____

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		
Eczema?	☐ Yes ☐ No		
Psoriasis?	☐ 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: _____

Clinician Signature: _____ Date: _____