

Client Consultation Form

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Sex: Female Male

How were you referred to us? _____

Occupation: _____ Does your job require that you work outdoors? No Yes

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) Have you ever had a body spa treatment before? No Yes

If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

- | | | |
|--------------------------|----------|--|
| <input type="checkbox"/> | Type I | Fair skin tones—Always burns, never tans |
| <input type="checkbox"/> | Type II | Light skin tones—Burns easily, tans slightly |
| <input type="checkbox"/> | Type III | Fair to olive skin tones—Burns moderately, tans moderately |
| <input type="checkbox"/> | Type IV | Light brown skin tones—Burns slightly, tans easily |
| <input type="checkbox"/> | Type V | Dark brown skin tones—Rarely burns, tans easily |
| <input type="checkbox"/> | Type VI | Dark brown to black skin tones—Never burns, tans easily |

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

If yes, please specify: _____

5) Have you ever had chemicals peels, laser treatments, or microdermabrasion? No Yes

In the last month? No Yes

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

If yes, please specify what and when last used: _____

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

8) Have you experienced Botox, Restylane, or collagen injections? No Yes

If yes, please specify: _____



Client Consultation Form — Continued

9) What skin care products are you currently using? (List brands if known)

Cleanser _____ Toner _____

Day Moisturizer _____ Night Moisturizer _____

Exfoliator _____ Mask _____

Eye Product _____ SPF/Sunscreen _____

Scrubs _____ Makeup Products _____

Soap _____ Shower Gels _____

Body Lotions _____ Other _____

10) Have you used any hair removal methods in the past six weeks? No Yes (Check all that apply)

Shaving Waxing Electrolysis Plucking Tweezing
 Stringing Depilatories Other: _____

11) What areas of concern do you have regarding your: **Skin** (Check all that apply)

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

Eyes (Check all that apply)

Dehydrated Wrinkles Puffiness
 Dark circles Other: _____

Lips (Check all the apply)

Dehydrated Cracked/chapped lips Other: _____

12) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____

Cosmetics AHAs Medication
 Fragrance Food Shellfish
 Animals Latex Sunscreens
 Drugs Iodine Pollen
 Other: _____

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

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

If yes, please specify: _____

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

If yes, please specify: _____

