

Name _____

Address _____

City _____ State _____ Zip _____

E-Mail _____

Cell Phone _____ Date of Birth _____

How did you hear about us? (If a friend, please give us their name so we can thank them!)

Your Health

Within the last year, have you been under a dermatologist or physician's care? yes no

If yes, please specify: _____

Within the last nine months, have you undergone any surgery? yes no

If yes, please specify: _____

List any prescription or over-the-counter medications, supplements, vitamins, etc., taken regularly:

Do you smoke? yes no Do you exercise regularly? yes no

On a restricted diet? yes no Do you wear contact lenses? yes no

Do you have metal implants, a pacemaker or body piercing? yes no

Rate your level of stress on a scale of 1 to 4 (1 = low, 4 = high): 1 2 3 4

Your Skin

Do you have any special skin problems pertaining to your face or body? yes no

If yes, please specify: _____

What skin care products are you currently using? (circle all that apply):

Face: soap cleanser toner moisturizer masque exfoliator eye products

Body: soap shower gel scrubs oil body moisturizer depilatory self-tanner

Have you ever had problems with wax products? yes no

If yes, please specify: _____

Exfoliation History

Have you had a chemical peel, microderm, or any resurfacing treatment? yes no In the last month?

Use Accutane, Retin A, Renova, or any other prescription skin products? yes no In the last 3 mos?

Are you currently using any products that contain the following ingredients?

glycolic acid lactic acid exfoliating scrub hydroxy acid vitamin a derivatives

Moisture Hydration

glasses of water daily? _____ # alcoholic drinks consumed weekly? _____

Do you ever experience these conditions on your skin: flakiness tightness dryness

What SPF sunscreen do you use on your face? _____ body? _____

Do you sunbathe or use tanning beds? yes no



SKINCARE INTAKE

Capillary Activity

- Do you burn easily in moderate sunlight? yes no
- Do you blush easily when nervous? yes no
- Do you have a tendency toward redness? yes no
- Do you suffer from sinus problems? yes no

Oil Secretion

- Do you experience oily shine? yes no
- Do you experience skin breakouts? yes no

Nerve Activity

- Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) yes no
- Do you ever experience a burning, itching sensation on your skin? yes no
- What is your pain threshold? Low Medium High
- Have you ever experienced claustrophobia? yes no
- What type of massage pressure do you prefer? Light Medium Firm

Have you ever had an allergy to nuts? yes no

Have you ever had a reaction or an allergy to any of the following?

- | | | | | | | | |
|------------------|--------------------|----------------------|-------------------|------------------------|----------------------|--------------|----------------|
| <i>cosmetics</i> | <i>medicine</i> | <i>iodine</i> | <i>pollen</i> | <i>waxing products</i> | <i>hydroxy acids</i> | | |
| <i>pumpkin</i> | <i>blueberries</i> | <i>fragrance</i> | <i>sunscreens</i> | <i>soy</i> | <i>sesame</i> | <i>wheat</i> | <i>coconut</i> |
| <i>almond</i> | <i>walnut</i> | <i>algae extract</i> | <i>macadamia</i> | <i>kukui</i> | <i>hazelnut</i> | | |

Do you have allergies to anything not listed above? _____

Female Clients Only

- Are you taking oral contraception? yes no
- Are you pregnant or trying to become pregnant? yes no
- Are you lactating? yes no

Male Clients Only

- What is your current shaving system? electric wet shave
- Do you experience irritation from shaving? yes no
- Do you experience ingrown hairs? yes no

Questions to Discuss Every Visit

- Are you currently having or due for your menstrual period? yes no
- Have you started any new medication since your last visit? yes no
- Have you taken antibiotics within the last 7 days? yes no
- What are your skin care goals? _____

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. **Please Note:** Accutane, Retin A, Renova and antibiotics can cause your skin to thin. Waxing and using exfoliants while using these products can tear and could result in scarring. Please do not withhold this information when asked by your skincare therapist.

Client Signature _____ Date _____