Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email: _____

Phone: _____ **Birthday:** _____

Please check any of the following that apply to you:

☐ Currently have a fever?

☐ Currently have any cold/flu like symptoms?

☐ Exposed to COVID in the last 10 days?

☐ Tested for COVID/tested positive for COVID in the last 10 days?

☐ COVID vaccinated?

☐ Previously had COVID?

☐ Chemical peel, Microdermabrasion, or other skin resurfacing in the past 30 days?

☐ Waxed within the last 72 hours?

☐ Used Retin-A, Renova, Adapalene or any other prescription skin products in the last 2 weeks?

Within the last year, have you had any health problems, surgeries, or any scars that have affected or could affect your skin care? ☐ Yes ☐ No

If yes, please explain: _____

_____

Are you currently taking medication(s)/supplement(s)? (Prescription and over the counter. Such as, but not limited to: vitamins, diuretics, slimming pills, oral contraceptives, Isotretinoin, blood thinners, steroids (oral or topical), antibiotics, anti-inflammatory, or other blood thinners) ☐ Yes ☐ No

If yes, please list: _____

_____

_____

Please check if any of the following apply to you:

☐ Pregnant ☐ Trying to become pregnant ☐ Lactating ☐ Menstruating ☐ Pre-menstrual

Are you allergic to:

☐ Latex ☐ Apples ☐ Aspirin ☐ Dairy ☐ Nuts ☐ Tea Tree
☐ Lavender ☐ Chamomile ☐ Vitamin E ☐ Rose Hip ☐ Glycerin ☐ Grapeseed
☐ Lemon Grass ☐ Vitamin K ☐ Vitamin C ☐ Licorice ☐ Frankincense

Do you have any other allergies? ☐ Yes ☐ No ***If yes, please list:*** _____

_____

Please check the box(es) for any of the following you currently have/have had:

☐ Telangiectasia ☐ Corpus/Purpura ☐ Varicose Veins ☐ Rosacea ☐ Eczema
☐ Sensitive skin ☐ Other skin conditions ☐ Uncontrolled high blood pressure
☐ Sinus problems ☐ Claustrophobia ☐ Back injury ☐ Neck injury
☐ Shoulder injury ☐ Hep A/B/C ☐ Hemophilia ☐ Sensitivity to hot/cold
☐ Loud noises ☐ HIV/Aids ☐ Cancer ☐ Chemo ☐ Lupus
☐ Immune therapy ☐ Chronic migraine ☐ Epilepsy ☐ Diabetes ☐ Seizures
☐ Liver conditions ☐ Kidney conditions ☐ Inflammation ☐ Botox/other injections
☐ Heart disease ☐ Silicone implants ☐ Metal implants ☐ Alcohol in last 24hrs
☐ Laser treatment ☐ Active cold sore(s) ☐ Sunbathe ☐ Use tanning bed
☐ Sun Burn ☐ Recent Tattoo(s) ☐ Contact lenses ☐ Body piercings
☐ Pacemaker ☐ Defibrillator ☐ Port ☐ Implanted pain stimulator

1. What is your daily water intake like? ☐Good ☐Moderate ☐Needs Improvement
2. What is your daily sugar intake like? ☐Good ☐Moderate ☐Needs Improvement
3. What is your stress level? ☐Good ☐Moderate ☐Needs Improvement
4. What is your fast-food intake like? ☐Good ☐Moderate ☐Needs Improvement
5. Do you work in the sun daily? ☐Yes ☐No
6. Did you recently move from out-of-state? ☐Yes ☐No
7. Is this your first skin care treatment? ☐Yes ☐No
8. Do you use SPF 30 daily? ☐Yes ☐No
9. Have you ever had an adverse reaction during a skin care treatment? ☐Yes ☐No
10. Do you have any specific concerns about your skin? ☐Yes ☐No
11. Do you have any questions about any treatments? ☐Yes ☐No
12. Are there any treatments you have always wanted to try? ☐Yes ☐No

If yes to any of the above questions 1 - 12, please list: _____

_____

Please check the skin care products you currently use at home:

☐Soap ☐Cleanser ☐Toner ☐Moisturizer ☐Masque ☐Exfoliant ☐Other

Please check if you are currently using any products that contain the following ingredients?

☐Glycolic Acid ☐Lactic Acid ☐Salicylic Acid ☐Other AHA/BHA/PHA

Do you want help developing an "at-home" skin care routine? ☐Yes ☐No