**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

Lavendar Chamomile Vitamin E Rose Hip Glycerin GrapeseedLemon 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 Tatoos 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