Client history

Name:_____

Address:_____

City:_____State:_____Zip:_____

Mobile:_____Home:_____Email:_____

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin cares needs.

Your Health

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

Do you smoke? Yes No

Do you exercise regularly? Yes No

do you follow 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)._____

Within the last nine months, have you undergone any surgery? Yes No

if yes, please specify_____

Have you had any health problems in the past or present? Yes No

if yes, please specify_____

List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly?

Have you had any of the following? (circle all that apply) cosmetic surgery botox dermatitis Skin cancer keloid scarring hepatitis other:_____

Your skin

Do you have any 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) Soap cleanser toner moisturizer masque scrub eye product Accutane Glycolic Acid/ Alpha Hydroxy Acid topical vitamin C hydroquinone retinoid (vitamin A derivatives)

Which conditions do you want to improve? (circle all that apply) hyper-pigmention (brown spots) acne/acne scarring sun damage enlarge pores fine lines & wrinkles age spots surgical facial scars other:_____

Have you ever had an allergic reaction to any skin products? Yes No

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? Yes No

if yes, when?

Moisture hydration

How much water do you consume daily?

How much alcoholic beverages do you consume weekly?

Do you ever experience these conditions on your skin? (circle all that apply) flakiness tightness obvious dryness

What SPF (sunscreen/ block) do you use on your face?_____Body?_____

Do you sunbathe or participate in out door activities? 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 a reaction to any of the following? cosmetics medicine iodine pollen hydroxy acids animals fragrance sunscreens other:		
Are you allergic to Aspirin?	Yes	No
Do you have any other allergies? (Food, Wheat, Pollen, etc...) if yes, please list:	Yes	No

Have you ever had Herpes (cold sores)? Yes No

Have you ever been treated with Zovirax or any medication for Herpes? Yes No

Do you have Epilepsy or Diabetes? Yes No

if yes, you will be treated only with a doctor's release!

Capillary activity		
Do you burn easily?	Yes	No
Do you blush easily when nervous?	Yes	No
Do you have a tendency to redness?	Yes	No
Do you suffer from sinus problems?	Yes	No

Female clients		
Are you on hormone replacements therapy?	Yes	No
Are you presently taking birth control pills?	Yes	No
Are you pregnant or planning to be?	Yes	No

General Information

What skin care products line are you currently using_____

What is it about your skin you would like to change?_____

Is there any other information I should know before beginning your treatment?_____

_____

Client signature_____Date_____

How did you here about us?_____ Add to email list? YES NO