



Name _____ DOB ____/____/____

Address _____

Ph# _____ Email: _____

How did you hear about me? _____

Tell me about your skin:

Are you under the care of a dermatologist? Yes No

Reason: _____

Within the last 9 months have you undergone facial surgery? Yes No

Month? _____

Do you smoke? Yes No Do you sunbathe or use tanning beds? Yes No

Any health problems past or present?

Do you have any metal implants/pacemaker or piercings? Yes No

Do you have any skin conditions I should be aware of?

What skin care products do you currently use? Please check all that apply:

Cleanser _____

Toner _____ Moisturizer _____ Mask _____ Exfoliate _____ EyeCream _____ SPF _____

Name of brand: _____

Do you take probiotics? Yes No Do you have a seizure disorder? Yes No

How much water to you drink daily? _____ ounces

Have you ever had a chemical peel, microdermabrasion or any other resurfacing treatment?

Yes No If yes, when?

Have you used Accutane, Retin A, Renova, Adapalene or any other prescription skin care products? Yes No If yes, have you used them in the last 3 months?

Yes No Do you take any steroidal medications? Yes No

Check any of the following skin conditions that you experience:

Flakiness____ Oily ____

Tightness____ Dry____ Breakouts____ Redness____ Rosecea ____

Please list any allergies and/or negative skin reactions:

What are two things that I can help you change or prevent in your skin?

Female clients only:

Are you taking any oral contraceptives: 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 method? Electric____ Razor ____

Do you experience irritation from shaving? Yes No

Do you experience ingrown hairs? Yes No

Signature _____ Date ___/___/___

This information is strictly confidential and will be used to correctly evaluate your individual skin care needs. This information will not be shared with a 3rd party.