Client Intake & Consultation

Name: _____ **Date of Birth:** _____/_____/_____

Address: _____

Telephone: (_____)_____ **E-Mail:** _____ Okay to e-mail? ☐ Yes ☐ No

Emergency Contact: _____ **Telephone:** (_____)_____

Your Skin Goals and Concerns: _____

_____

Your Skin Type: ☐ Normal/Combo ☐ Oily ☐ Sensitive ☐ Dry ☐ Mild Acne ☐ Moderate Acne ☐ Mature & Aging

What skin products are you currently using? _____

_____

_____

What makeup products are you currently using? _____

_____

Does your job and lifestyle require that you work/play outdoors? _____

Do you wax your facial skin on a regular basis? ☐ Yes ☐ No If yes, when was the last time? _____

Have you ever had facials, chemical peels, microdermabrasion or any resurfacing treatments? ☐ Yes ☐ No
If yes, was it within the last month? ☐ Yes ☐ No

Are you using Retin-A? ☐ Yes ☐ No Are you using Benzoyl Peroxide? ☐ Yes ☐ No

Do you have any allergies or sensitivities? _____

Have you ever experienced a reaction to any of the following?
☐ Cosmetics ☐ medicine ☐ iodine (shellfish) ☐ latex ☐ pollen ☐ food/fruit ☐ animals' ☐ fragrance ☐ alpha hydroxy acids ☐ sunscreens

Do you have any of the below health issues?:

Cancer?	☐ Yes ☐ No	Chemotherapy?	☐ Yes ☐ No
Circulatory issues?	☐ Yes ☐ No	High blood pressure?	☐ Yes ☐ No
Arthritis?	☐ Yes ☐ No	Hysterectomy?	☐ Yes ☐ No
Hormonal imbalances?	☐ Yes ☐ No	Thyroid?	☐ Yes ☐ No
Diabetes?	☐ Yes ☐ No	Pregnant?	☐ Yes ☐ No
Lactating?	☐ Yes ☐ No	Planning to be pregnant?	☐ Yes ☐ No
Psoriasis?	☐ Yes ☐ No	Recent surgeries?	☐ Yes ☐ No
Cold Sores?	☐ Yes ☐ No	Eczema?	☐ Yes ☐ No

Do you take any medications? _____
Accutane? ☐ Yes ☐ No Antibiotics? ☐ Yes ☐ No Birth Control? ☐ Yes ☐ No

I have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive are voluntary and I release the company and/or skin care professional from liability.

Signature: _____ Date: _____