HOLISTIC SKIN CARE TAMPA

LOVE YOUR SKIN <3

Client Information

DATE: _____

RETURNING CLIENTS | Any changes since last visit? ❍ **No** ❍ **Yes** *If yes please indicate changes on form.*

CLIENT NAME: _____ **GENDER:** ❍ **M** ❍ **F** **DOB** _____

ADDRESS _____ **CITY**_____ **STATE**_____ **ZIP** _____

PREFERRED CONTACT NUMBER _____ **EMAIL** _____

May we leave a message if we do not reach you personally? ❍ No ❍ Yes

WHAT ARE YOUR TOP 3 SKINCARE CONCERNS:

1. _____
2. _____
3. _____

MEDICAL HISTORY: Pregnant? ❍ No ❍ Yes Breastfeeding? ❍ No ❍ Yes

Do you smoke? ❍ No ❍ Yes

Health Conditions: _____

Past Surgeries: _____

Have you ever been diagnosed with Cancer? ❍ No ❍ Yes (last treatment date)_____

Current Medications: _____

Prescription Topicals: _____

Allergies (include aspirin & iodine): _____

PREVIOUS TREATMENTS:

Facials	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Microdermabrasion	❍No ❍Yes	Last treatment: _____	Any complications?_____
Chemical Peels	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Waxing	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Tanning	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Laser Therapy	❍ No ❍ Yes	Last treatment: _____	Any complications?_____
Massage	❍ No ❍ Yes	Last treatment: _____	Any complications?_____

SKIN CONDITIONS: *(please check all the items below that pertain to you)*

❍ Skin Infection	❍ Herpes (cold sores)	❍ Keloids/Excessive Scarring	❍ Sun Sensitivity
❍ Skin Cancer	❍ Poor Healing	❍ Tattoos/Permanent Makeup	❍ Easy Bruising
❍ Eczema	❍ Psoriasis	❍ Lymph Nodes Removed	❍ Diabetes

SKINCARE: What type of skin do you feel you have? ❍ Dry ❍ Oily ❍ Normal ❍ Combination

What is your skin routine? *(Indicate any cleansers, toners, serums, moisturizers, masques, etc.)*

1._____ 4._____

2._____ 5._____

3._____ 6._____