Skin Care Client Intake Form

Name ____

Address ____

City ____________________________________ State __________ Zip ____________

Home Phone _____________________________ Date of Birth _____________ Age _____

Cell Phone _____________________________Email Address _____________________________

Have you ever had a facial before? Yes No If so, when? ____________________

What type of skin do you have? Oily Skin Dry Skin Combination

Acne Breakout Normal

What skin care products do you use? Soap Cleanser Toner

Masque Scrub/Peel Moisturizer Sunscreen Other __________

What temperature water do you use to cleanse with? Cool Warm Hot

Do you have any special skin care problems pertaining to your face and/or body? Yes No
If yes, please explain ____

Have you had any reaction to any of the following? Cosmetics Medicine

Aspirin Fragrance Sunscreen Pollen Iodine AHAs

Animals Food ____________ Other ______________________

Do you burn easily in moderate sunlight? Yes No Do you use Retin-A? Yes No

Do you wear contact lenses? Yes No

Have you had chemical peels before? Yes No

How much plain water do you consume daily? _________________
How many alcoholic beverages do you consume per week? _______
How many caffeinated beverages do you consume a day? _______
Do you smoke? Yes No

Are you currently seeing a physician for a specific medical reason? Yes No
If yes, please explain ____

Do you currently take any medications or vitamins? Yes No
If yes, please specify____