Chakra Esthetics
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New Client - Confidential Health History Form & Skin Consultation

The following information is REQUIRED by the California State Board of Cosmetology, Associated Skin Care Professionals and Chakra Esthetics. If you are unwilling to provide completed pertinent information, then your service will be declined today - NO EXCEPTIONS!

Todays Date:_____ Date of Birth:_____

Name (Printed):_____

Address:_____City:_____ State:_____ Zip:_____

Cell Phone:(_____)_____ Cell Phone Carrier:_____

Email Address:_____@_____ Home Phone:(_____)_____

Emergency Contact Name:_____ Phone:(_____)_____

(Please check one of the following)
Full-Time Resident: ____ Yes ____No Part-Time Resident:____Yes ____No Visitor:____Yes ____No

Have you had any of these health conditions in the past or presently? **(Please check all that apply)**

____ Cancer
____ Spinal Injury
____ Diabetes
____ Asthma
____ Hepititis
____ HIV/AIDS
____ Lupus
____ Any Active Infection
(Colds, Flu, Strep, Mono, etc.)
____ Hormone Imbalance
____ Thyroid Condition
____ Heart Problem
____ Eczema
____ Chronic Headaches
____ Immune Disorders
____ Phlebitis/Blood Clots/Circulation
____ Skin Disease/Lesions
____ High Blood Pressure
____ Hysterectomy
____ Arthritis
____ Seizure Disorder/Epilepsy
____ Herpes
____ Frequent Cold Sores
____ Insomnia
____ Psychological Treatment

1) Do you smoke or vape? ____ Yes ____ No **(NO judgements here)**
2) Do you follow a restricted diet? ____Yes ____No
3) Exercise regularly? ____Yes ____No
4) What is your current stress level today? ____Low ____ Medium ____High
5) Have you ever used **ACNE medications** before? ____Yes ____No When?_____ **Drug Name**:_____
6) Do you form thick, raised, **keloid scars** from cuts or burns? ____Yes ____No
7) Do you have **Hyperpigmentation** (darkening of the skin) or **Hypopigmentation** (lightening of the skin) or marks after physical injury? ____Yes ____No
8) How frequently are you exposed to the sun? ____Infrequently ____Frequently ____Regularly
9) Do you have a **pacemaker** or other **metal implants**? ____Yes ____No. If so, where?:_____
10) Have you experienced **Claustrophobia**? ____Yes ____No
11) Have you ever had an **adverse reactions** after using skin care products? **(Circle all that apply)**
Rash Irritation Sun Sensitivity Peeling Break Outs

12) Have you ever had an **allergic reactions** to any of the following? **(Circle all that apply)**
Cosmetics Medicine Food Animals SPF Iodine Pollen Fragrance Shellfish Latex AHA's

13) **Medications & Supplements** you are currently taking:_____

Female Clients Only:

14) Are you taking **oral contraceptive**? ____Yes ____No Specify:_____
15) Any **recent changes** to your contraceptive treatment? ____Yes ____No If so, what changes?_____
16) Are you **pregnant** or trying to become pregnant? ____Yes ____No Lactating? ____Yes ____No
17) Are you currently in **Menopause** (all periods have stopped for at least 2 years)? ___Yes ___No
18) Currently taking **Hormone Replacements (HRT)**? ___Yes ___No
If so, what types (pills, creams, medication names)?_____

Male Clients Only:

19) What is your current shave preference? ____ Wet Shave ____Electric
20) Do you experience irritation from shaving? ____Yes ____No Ingrown hairs? ____Yes ____No

Your Skin Care

21) Which of the following best describes your **Fitzpatrick Skin Type**? **(Please circle one description type)**

TYPE		
I	Fair/Light Complexion	Always burns, never tans
II	Light Complexion	Always burns, tans slightly
III	Light/Matte Complexion	Burns moderately, tans gradually
IV	Matte Complexion	Seldom burns, always tans well
V	Brown Complexion	Rarely burns, tan deeply
VI	Dark Brown Complexion	Rarely burns, deeply pigmented

22) Do you have any special **skin problems** or concerns pertaining to your face or body? ___Yes ___No
Please specify:_____
23) Have you ever had **chemical peels**, **laser** or **microdermabrasion**? ___Yes ___No
In the last month? ___Yes ___No Which ones?_____
24) Do you use **Retin-A, Renova, Adapalene Hydroxyl Acid (AHA) or Retinol/Vitamin-A derivative** products? ____Yes ____No Specify:_____
25) Have you used any of these products in the last 3-12 months? ____Yes ____No
26) Do you spray tan or use a tanning lotion? ____Yes ____No
27) Have you used any of the following hair removal methods in the past 6-weeks? **(Circle all that apply)**

Shaving *Waxing/Sugaring* *Tweezing* *Threading* *Electrolysis* *Hair Removal Creams*

28) What area of concern do you have regarding your skin? **(Please check the following that apply)**

____ Breakouts/Acne
____ Rosacea
____ Uneven Skin Tone
____ Dull/Dry Skin
____ Cracked Lips
____ Blackheads/Whiteheads
____ Broken Capillaries
____ Sun Damage
____ Flakey Skin
____ Dark Circles (Eyes)
____ Excessive Oil/Shine
____ Redness/Ruddiness
____ Wrinkles/Fine Lines
____ Dehydrated Skin
____ Puffiness (Eyes)

29) What skincare brands do you use for the following: **(Please fill in all that apply - NO judgements here)**

Bar Soap/Shower Gels_____
Face Cleanser_____
Face Masks_____
Eye Products_____
Face Moisturizers (day)_____
Sunscreens/Strength_____
Body Moisturizers_____
Face Toner_____
Face Serums_____
Exfoliator/Scrubs_____
Face Moisturizers (night)_____
Makeup Brands_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or Witten disclosures. 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 here are voluntary and I release Associated Skin Care Professionals and/or skin care professional from liability and assume full responsibility thereof. If you'd like a copy of this completed form, one will be provided to you.

Client Signature:_____ Date:_____