CONFIDENTIAL CLIENT SKIN CONSULTATION Today's Date: _____

Name: _____ Date of Birth: ____/____/_____
Address: _____ City, State, Zip _____
Home Phone: _____ Business Phone: _____
Cell Phone: _____ E-mail address: _____
Emergency Contact Person: _____ Phone: _____
Single ☐ Married ☐ If married, anniversary date/year: _____ Referred by: _____
Employer: _____ Occupation: _____
Does your job require that you work outdoors? ☐ No ☐ Yes
What would you like to achieve from your treatment today?

_____

Your Skin Care

1) Have you ever had a facial treatment before? ☐ No ☐ Yes, when? _____ how often? _____

2) What areas of concern do you have regarding your skin, eyes and lips: (Please check any below & explain)

SKIN:				**EYES:**		**LIPS:**	
Breakouts/acne	☐	Uneven skin tone	☐	Dehydrated	☐	Dehydrated	☐
Blackheads/whiteheads	☐	Sun damage	☐	Wrinkles	☐	Cracked	☐
Excessive oil/shine	☐	Wrinkles/fine lines	☐	Puffiness	☐	Chapped	☐
Rosacea	☐	Dull/dry skin	☐	Dark Circles	☐		
Broken capillaries	☐	Flaky skin	☐				
Redness/ruddiness	☐	Dehydrated	☐				
Sun spots//brown spots	☐	Other _____					

3) What skin care products are you currently using? (List brands where known)

Bar Soap _____ Serum/Concentrate _____
Cleanser _____ Night Moisturizer/Cream _____
Exfoliator/Scrubs _____ Mask _____
Toner _____ Shower Gels _____
Eye Cream _____ Body Scrubs _____
Day Moisturizer _____ Body Lotions _____
Sunscreen _____ Other _____
Makeup Products _____ _____

4) What SPF do you use on your face? _____ What SPF do you use on your body? _____

Do you use it (circle one) Sporadically Once Daily in the morning Reapply throughout the day

5) Have you ever had an **allergy or reaction** to any of the following? (Please check any that apply & explain)

Cosmetics	☐	AHAs	☐	
Medicine	☐	Fragrance	☐	Other: _____
Food	☐	Shellfish	☐	
Animals	☐	Latex	☐	If yes, please explain further: _____
Sunscreens	☐	Drugs	☐	
Iodine	☐	Aspirin	☐	_____
Pollen	☐	Sulphur Compounds	☐	

6) Do you have any metal plates, a pacemaker, or piercings in your body? _____

7) Do you have any special skin problems or concerns pertaining to your face or body? ☐Yes ☐ No
Please specify: _____

8) Are there any concerns or injuries to ANY areas of your body that I need to be aware of in terms of doing massage? Please specify: _____

9) Do you have any condition that has been diagnosed by a physician? _____

10) Any surgeries or cosmetic procedures, injections, fillers, etc? _____

_____

11) Which of the following best describes your skin? (Please circle one number)

I	Creamy complexion	Always burns easily, 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, deep tan
VI	Black Complexion	Never burns, deeply pigmented

12) Have you recently used any self-tanning lotions, creams or treatments? ☐ No ☐Yes, specify: _____
13) Have you had any recent tanning bed or sun exposure that changed the color of your skin? ☐ No ☐Yes
specify: _____

14) Do you use Retin-A, Renova, Adapalene, Hydroxy Acids or Retinol/Vitamin A derivative products?
☐ No ☐Yes describe: _____
15) Have you used any of these products in the last 3 months? ☐ No ☐Yes

16) Have you used an acne medication? ☐ No ☐Yes When? _____ Which drug? _____

17) Have you ever had chemical peels, laser or microdermabrasion? ☐ No ☐Yes
In the last month? ☐ No ☐Yes

18) Have you used any of the following hair removal methods in the past six weeks? ☐ No ☐Yes
Please circle all that apply: Shaving Waxing Electrolysis Tweezing Threading Depilatories

Female Clients Only:

19) Are you taking oral contraceptives? ☐ No ☐Yes specify: _____
20) Any recent changes to or from your contraceptive treatment? ☐ No ☐Yes
If so, what and when: _____
21) Are you pregnant or trying to become pregnant? ☐ No ☐Yes
22) Are you lactating? ☐ No ☐Yes
23) Are you in peri-menopause, menopause or post-menopause? ☐ No ☐Yes
24) Are you undergoing any hormone replacement therapy? ☐ No ☐Yes

Male Clients Only:

25) What is your current shaving system? Wet shave ☐ Electric ☐
26) Do you experience irritation from shaving? ☐ No ☐Yes Ingrown hairs? ☐ No ☐Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

_____

_____

Future Appointments/Contact:

May I call you at your home, work or cell phone number to confirm future appointments? ☐ No ☐Yes
May I contact you via mail/email about future promotions, specials, and news? ☐ No ☐Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written 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 this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

FOR SKIN THERAPIST USE ONLY: Alerts/Precautions:

Skin Type: Condition:
Additional Notes & Treatment Protocols: