Skincare Consult

Date		
Name	Date of Birth	
Phone	E-mail address	
Occupation		

HEALTH CONDITIONS:

DO YOU SMOKE?

KNOWN ALLERGIES:

MEDICATIONS:

ANY CHRONIC PROBLEMS:

What would you like to achieve from your treatment today?

<u>Your Skin Care</u>

1) Have you ever had a facial treatment before? No/Yes: When?

2) Which of the following best describes your skin type? (Please mark one type)

	Creamy complexion	Always burns easily, never tans
	Light Complexion	Always burns, tans slightly
	Light/Matte Complexion	Burns moderately, tans gradually
	Matte Complexion	Seldom burns, always tans well
	Brown Complexion	Rarely burns, deep tan
	Black Complexion	Never burns, deeply pigmented

3) Do you have any special skin problems or concerns pertaining to your face or body?
Yes/No:
Specify:

4) Have you ever had chemical peels, laser or microdermabrasion? No Yes In the last month? No/Yes:

5) Have you ever used a retinoid? (Retin-A, Retinol, Retinaldehyde) No/Yes:

6) Have you used an acne medication? No/Yes: when?
Which drug?

7) Have you ever used medical grade vitamin c? Yes/no:
(Any continued sensitivity to it?) Yes/no:

8) What is your current skincare routine? (List brands where known)

9) Have you used any of the following hair removal methods in the past six weeks?
No/yes: Mark all that apply:

Shaving		Waxing		Electrolysis		Tweezing		Stringing		Depilatories	

10) What skin concerns do you have? (Please check any that apply)

Acne/Oily skin	
Preventative Anti-aging	
Wrinkles, fine lines, sagging skin	
Melasma, discoloration, uneven skin tone, brown or sun spots	
Rough/dry skin	
Redness/sensitive skin	
Eyes- fine lines, crows feet	
Prevention	

11) Does your skin ever feel dry? (Please check any that apply)

Yes, all the time	
Sometimes, only in the winter and not in the summer	
No, it feels oily, combination, or oily throughout the year	
Yes, but only when using certain products (retinoids, topical acne treatments, etc)	

12) Does your skin get easily red, flushed, or feel warm to the touch?

Yes, my skin can stay red for long periods of time and/or is rosacea prone	
Yes, my skin gets red after a shower, physical activity, or using certain products but doesn't stay that way for long	
No, this is not an issue for me	

13) Is your skin sensitive or reactive?

Yes, always	
Sometimes, when using strong topical products	
No, I never have sensitivity or reactions to products	

14) How often does your skin breakout?

Never	
Rately (1-2/month)	
Occasionally (3-4 times/month)	
Often (multiple breakouts/week)	
All the time (breakouts daily)	

15) What SPF do you use on your face? How often/when?

16) Do you prefer clear or Tinted SPF?

17) Have you experienced Botox, Filler or Collagen injections? No/Yes:
Specify:

Female Clients Only:

18) Are you taking oral contraceptives? No/Yes:
Specify:

19) Any recent changes to or from your contraceptive treatment? No/Yes:
If so, what and when:

20) Are you pregnant or trying to become pregnant? No/Yes:

21) Are you lactating? No/Yes:

22) Any menopause problems? No/Yes:
Specify:

23) Are you undergoing any hormone replacement therapy? No/Yes:
Specify:

Male Clients Only:

24) What is your current shaving system? Wet or Electric shave:

25) Do you experience irritation from shaving? No/Yes: Ingrown hairs? 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 skincare professional from liability and assume full responsibility thereof

Client Signature:
Date:

Practitioner/Physician Signature:
Date: