Confidential Client Health History & Consultation Form (Please complete all 3 pages)

Date:___________________________ Male__ or Female__

Name:____ Date of Birth:________________

Address:____

Email:_____________________________________ How did you hear of us?_______________

Cell Phone:_________________________________ Home:_____________________________

Physician:_______________________________________ Phone:________________________

Emergency Contact:______________________________ Phone:________________________

Your Health

1. Have you been under the care of a physician, dermatologist or other medical professional within the past year? __No __Yes, explain:__________________________
2. List any recent surgery, (last 6 months)____
3. Any skin cancer? __No __Yes, explain:____
4. Have you had any piercings, tattoos, or permanent cosmetics __No __Yes, where and when?____
5. Have you had any of these health conditions in the past or present?
   (Please check all that apply and provide additional information in the space provided)

   __Cancer __Hormone imbalance __Systemic disease
   __High blood pressure __Spinal injury __Thyroid condition
   __Hysterectomy __Diabetes __Heart problems
   __Varicose veins __Arthritis __Asthma
   __Eczema __Epilepsy __Seizure disorder
   __Fever blisters __Headaches (chronic) __Hepatitis
   __Herpes __Frequent cold sores __Immune disorders
   __HIV/AIDS __Lupus __Metal pins/plates
   __Phlebitis, blood clots __Psychological treatment __Insomnia
   __Keloid scarring __Skin disease/skin lesions __Active infection
   __Claustrophobia __Sinus problems __Allergy
   Other____
6. Do you smoke? __No __Yes
7. Do you have a pacemaker/defibrillator? __No __Yes
8. Do you wear contact lenses? __No __Yes
9. List any medication and over the counter supplements you take regularly: ___________
   ____
   ____
10. Do you have hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? __No __Yes

11. Have you had microneedling, chemical peels, laser or microdermabrasion? __No __Yes
    If yes what was the date of your last treatment? ___________________

12. Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)
    __Cosmetics __Medicine __Food __Animals __Sunscreen __Iodine
    __Pollen __AHA's __Fragrance __Shellfish __Latex __Drugs Other________
    ____

13. Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply) Rash Irritation Peeling Sun Sensitivity Breakout

14. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? __No __Yes
    If Yes, when was the last time you used them? ___________________________________

15. Have you been exposed to the sun or used a tanning bed in the last 48 hours? __No __Yes If yes how frequently are you exposed? __Infrequently __Frequently

16. Do you use sunscreens? __No __Yes What SPF do you use on your body____,face____?
17. What is your stress level? __High __Medium __Low

18. List your daily consumption of: Water________ Caffeine__________ Alcohol________

Female Clients Only:

1. Are you taking oral contraceptives or hormone replacement therapy? __No __Yes if so, what and when? ____
2. Are you pregnant or trying to become pregnant? __No __Yes

Male Clients Only:

1. What is your current shaving system? Wet shave_____ Electric______
2. Do you experience irritation from shaving? __No __Yes Ingrown hairs? __No __Yes

Future Appointments/Contact:

May I call or text you to confirm future appointments? __No __Yes
May I contact you via mail/email about future promotions and news? __No __Yes

Client Consultation

1. What skin care products are you currently using? (list brand where known)
   Soap ________________________________ Shower Gels ______________________
   Toner _______________________________ Body Lotions ______________________
   Mask ________________________________ Sunscreen ________________________
   Eye Product __________________________ SPF _____________________________
   Cleanser _____________________________ Night Moisturizer _________________
   Day Moisturizer ________________________ Other ____________________________
   Exfoliator _____________________________ Makeup Products _________________
   Scrubs ________________________________ Self Tanner ______________________

2. Have you recently used any of the following hair removal methods in the past six weeks? __No __Yes Circle all that apply.
   Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

3. What areas of concern do you have regarding your :
   Skin: (Please check any that apply and number according to importance to you)
   _____Breakouts/acne _____Uneven skin tone _____Blackheads/whiteheads
   _____Sun Damage _____Excessive oil/shine _____Wrinkles/fine lines
   _____Rosacea _____Dull/dry skin _____Broken capillaries
   _____Flaky skin _____Redness/ruddiness _____Dehydrated
   _____Sun spot/liver spot/brown spot _____Other___________________________
   Eyes:
   _____Dehydrated _____Wrinkles _____Puffiness _____Dark circles __other
   Lips:
   _____Dehydrated _____Cracked/chapped lips _____other

4. Which of the following best describes your skin type? (Please Circle one)
   I Creamy complexion – Always burns easily, never tans
   II Light Complexion- Always burns, tans slightly
   III Light/Matte Complexion-Burns moderately, tans gradually
   IV Brown Complexion- Rarely burns, deep tan
   VI Black Complexion-Never burns, deeply pigmented

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:______________