SKIN CARE
CLIENT CONSULTATION

NAME:____ DOB:______________

ADDRESS:____

CITY:____ STATE:_________ ZIP:_______________

PHONE:____

EMAIL ADDRESS:____

EMERGENCY CONTACT:__________________________________PHONE:______________________

YOUR HEALTH

Have you had any of the following conditions in the past or present? Please circle all that apply.

Cancer	Headaches (chronic)	Hormone imbalance
Hepatitis	Systemic Disease	Herpes
High Blood Pressure	Frequent Cold Sores	Immune Disorders
HIV/AIDS	Spinal Injury	Thyroid Condition
Hysterectomy	Lupus	Diabetes
Heart Problem	Varicose Veins	Metal bone pins or plates
Arthritis	Asthma	Phlebitis, blood clots, poor circulation
Eczema	Blood Clotting abnormalities	Psychological treatment
Epilepsy	Skin Diseases/skin lesions	Seizure
Insomnia	Sinus Problems	Fever Blisters
Any active infection		

1. Have you been under the care of a physician, dermatologist or other medical professional within the past year?
YES NO If yes, please explain:____
2. Any recent surgery, including plastic surgery? YES NO
3. What would you consider your stress level? HIGH MEDIUM LOW
4. Do you wear contact lenses? YES NO
5. Do you have any metal implant, metal dental work or wear a pacemaker? YES NO
6. Have you ever experienced claustrophobia? YES NO
7. How many hours of sleep do you get each night?______________ Do you smoke? YES NO
8. How many 8 oz glasses of water do you consume each day?__________ Caffeine?____________________

YOUR SKIN CARE

1. What would you like to achieve from your treatment today?____

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2. Which of the following best describes your skin type? (Please circle a roman numeral to the left)

I	Creamy Complexion	Always burns easily, never tans
II	Light Complexion	Always burns easily, 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

3. Do you have any special skin problems or concerns pertaining to your face or body? Circle all that apply

Breakouts / Acne	Uneven Skin Tone	Slackheads/Whiteheads
Sun Damage	Excessive oil/shine	Wrinkles/Fine lines
Rosacea	Dull/dry skin	Flaky Skin
Broken capillaries	Redness/ruddiness	Dehydrated
Sun Spots / Liver Spots	Keloids (thick or raised scars	Hyperpigmentation (darkening of skin)
Other______________________	Stretch Marks	Hypopigmentation (lightening of skin)

Eyes: Dehydrated Wrinkles Puffiness Dark Circles Other:____________________________

Lips: Dehydrated Cracked or chapped Other:______________________

4. Have you ever had chemical peels, laser or microdermabrasion? YES NO In the last month? YES NO
5. Do you use Retin-A, Renova, Adapalene Hydrozyl A Acid, Deferin, Glycolic Acid, AHA, Salycyllic Acid or Retinol/ Vitamin A Derivative products? YES NO In the last 3 months? YES NO
6. Have you use an acne medication? YES NO If yes, when and which drug(s)?____________________________

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7. Have you recently used or had any self tanning lotions, creams or professional treatments? YES NO
   Please specify: ____
8. Have you use any of the following hair removal methods in the past six weeks?

   Shaving Waxing Electrolysis Plucking Tweezing Threading Depilatories

9. What SPF do you use on your face?________ How often / when?_____________________________________
10. What SPF do you use on your body?________ How often / When?____________________________________

11. Have you had any recent tanning bed or sun exposure that abnormally altered the color of your skin? YES NO

    Please specify:____

12. Have you been exposed to the sun or used a tanning bed in the last 48 hours? YES NO

13. How frequently are you exposed to the sun or use a tanning bed? Infrequently Frequently Regularly

14. Have you experience Botox, Collagen injections, Restylane, or any other fillers? YES NO

    Please specify:____

15. Have you ever had an allergic reaction to any of the following?

Cosmetics	AHAs	Medicine
Food	Fragrance	Shellfish
Animals	Latex	Sunscreen
Drugs	Iodine	Skin care products
Pollen	Other:_______________________	

If you circled any, please explain:____

____

16. What is your current facial skincare regiment?

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Questions 17-22 concern only female clients:

17. Are you taking oral contraceptives? YES NO

18. Any recent changes to or from your contraceptive treatment? YES NO

19. Are you pregnant or trying to become pregnant? YES NO

20. Are you lactating? YES NO

21. Are you currently in menopause? YES NO If so, have you experienced any related problems? YES NO

22. Are you undergoing any hormone replacement therapy? YES NO

Questions 23 & 24 concern only male clients:

23. What is your current shaving system? Wet Shave Electric

24. Do you experience any irritation from shaving? YES NO Ingrown Hairs? YES NO

FUTURE APPOINTMENTS / DISCLAIMER

What is the best way to confirm future appointments? TEXT EMAIL PHONE

I understand, have read and completed the 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 contradictions and/or irritation to the skin from treatments received. The treatments I receive at Hey Gorgeous Studio are voluntary and I release this institution from liability and assume full responsibility thereof.

Client Signature_______________________________________ Date:_____________________________