Skin Care Intake

Name: _____ DOB: _____ Age: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____Email: _____

About You:

- What is your hereditary background? (Circle all that apply): Nordic / Scandinavian / Irish / English / Asian / Mediterranean / Hispanic / Native American / Middle Eastern / African American / Other: _____
- Natural Eye Color: _____
- Natural Hair Color: _____
- Do you consider your skin (Circle the best option): Sensitive / Resilient / Unsure
- Describe your skin (Circle all that apply): Normal / Dry / T-Zone / Combination / Thick / Thin / Saggy / Firm / Oily / Acne / Comedones / Blackheads / Milia / Cysts / Breakouts / Acne-Scarred / Large Pores / Small Pores / Rosacea / Eczema / Freckled / Sun-Damaged / Melasma / Hyperpigmentation / Hypopigmentation / Uneven / Blotchy / Mature / Wrinkled /Patchy Dryness / Sallow / Psoriasis / Dehydrated / Lacking Moisture / Asphyxiated / Telangiectasia / Broken Surface Capillaries
- What are the changes you'd most like to see in your skin?
  _____
  _____
  _____

Lifestyle:

Check Yes or No

- Are you pregnant or lactating? Yes_____ No _____
  (Please consult with your obstetrician. Only the Oxygenating Trio, Detox Gel Deep Pore Treatment or Hydrate: Therapeutic Oat Milk Mask are appropriate.)
- Do you wear contact lenses? Yes _____ No _____
  (Remove contacts if eyes are sensitive or if having microdermabrasion.)
  Do you currently have a sunburned/windburned/red face? Yes _____ No _____
  Why? _____
- Are you in the habit of going to tanning booths? Yes _____ No _____
  (If within the past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)
- Do you participate in vigorous aerobic activity or sports? Yes _____ No _____
  What type? _____
- Do you smoke or use tobacco? Yes _____ No _____
- What kind of work do you do? _____
- On average, how many hours per week do you spend outdoors? _____

Medical / Treatment History:

Check Yes or No

- Do you currently use depilatories or wax? Yes _____ No _____
  (Discontinue use five days pre – and post-treatment.)
- Have you had a Chemical Peel or any type of procedure with a medical device? Yes _____ No _____
  Within the last 14 days? Yes _____ No _____
  What type? _____
- Do you have regular collagen, Botox or other dermal filler injections? Yes _____ No _____
  (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
- Have you recently had laser resurfacing or facial surgery? Yes _____ No _____
  Describe: _____
  When: _____
- Are you currently taking any medications, topical or otherwise? Yes _____ No _____
  (Tretinoin / Retin-A / Renova / Differin / Tazorac / Avage / EpiDuo / Ziana)
  Which one(s)? _____
  For how long? _____
  What strength? _____
  (High percentages of certain ingredients may increase sensitivity. Discontinue use after five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Have you ever undergone Accutane therapy (isotretinoin)? Yes _____ No _____
  (If you are currently using Accutane therapy (isotretinoin) please consult with your dispensing physician.)
  (If you are no longer using Accutane therapy (isotretinoin) it is **OK** to apply **ONE** layer of **Ultra Peel I, Sensi Peel, Advanced Treatment Booster, Oxygenating Trio, Hydrate: Therapeutic Oat Milk Mask** or **Revitalize: Therapeutic Papaya Mask**.)
- Do you develop cold sores / fever blisters? Yes _____ No _____
  Last breakout? _____
- Are you allergic / sensitive to (Circle all that apply): Yes _____ No _____
  Milk / Apples / Citrus / Grapes / Aloe Vera / Aspirin / Perfumes / Latex / Hydroquinone /Mushrooms?
  If any other allergies, what? _____
- Have you ever used any other products that caused a bad reaction? Yes _____ No _____
  Describe: _____

Client Consent:

1. All skin treatments should not be performed under certain medical conditions; therefore, I affirm that I have answered all questions pertaining to medical conditions and treatments thoroughly and truthfully.
2. I understand the 24-hour rescheduling policy and agree to the terms as mentioned on the company website. Rescheduling within 24 hours of your scheduled experience will incur the full-service fee.
3. I confirm and consent to before and after pictures for the purpose of tracking progress and promoting services.

Signature: _____ Date: _____

Signature of clinician: _____