SKINCARE INTAKE

Name ____

Address ____

City ______________________ State __________ Zip __________

E-Mail ____

Cell Phone ______________________ Date of Birth ______________

How did you hear about us? (If a friend, please give us their name so we can thank them!)

____

Your Health

Within the last year, have you been under a dermatologist or physician's care? ☐ yes ☐ no

If yes, please specify: ______________________________

Within the last nine months, have you undergone any surgery? ☐ yes ☐ no

If yes, please specify: ______________________________

List any prescription or over-the-counter medications, supplements, vitamins, etc., taken regularly:

Do you smoke? ☐ yes ☐ no Do you exercise regularly? ☐ yes ☐ no

On a restricted diet? ☐ yes ☐ no Do you wear contact lenses? ☐ yes ☐ no

Do you have metal implants, a pacemaker or body piercing? ☐ yes ☐ no

Rate your level of stress on a scale of 1 to 4 (1 = low, 4 = high): 1 2 3 4

Your Skin

Do you have any special skin problems pertaining to your face or body? ☐ yes ☐ no

If yes, please specify: ______________________________

What skin care products are you currently using? (circle all that apply):

Face: soap cleanser toner moisturizer masque exfoliator eye products

Body: soap shower gel scrubs oil body moisturizer depilatory self-tanner

Have you ever had problems with wax products? ☐ yes ☐ no

If yes, please specify: ______________________________

Exfoliation History

Have you had a chemical peel, microderm, or any resurfacing treatment? ☐ yes ☐ no In the last month?

Use Accutane, Retin A, Renova, or any other prescription skin products? ☐ yes ☐ no In the last 3 mos?

Are you currently using any products that contain the following ingredients?

glycolic acid lactic acid exfoliating scrub hydroxy acid vitamin a derivatives

Moisture Hydration

glasses of water daily? ________ # alcoholic drinks consumed weekly? ________

Do you ever experience these conditions on your skin: flakiness tightness dryness

What SPF sunscreen do you use on your face? ___________ body?___________

Do you sunbathe or use tanning beds? ☐ yes ☐ no

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Capillary Activity
Do you burn easily in moderate sunlight? ☐ yes ☐ no
Do you blush easily when nervous? ☐ yes ☐ no
Do you have a tendency toward redness? ☐ yes ☐ no
Do you suffer from sinus problems? ☐ yes ☐ no

Oil Secretion
Do you experience oily shine? ☐ yes ☐ no
Do you experience skin breakouts? ☐ yes ☐ no

Nerve Activity
Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) ☐ yes ☐ no
Do you ever experience a burning, itching sensation on your skin? ☐ yes ☐ no
What is your pain threshold? Low Medium High
Have you ever experienced claustrophobia? ☐ yes ☐ no
What type of massage pressure do you prefer? Light Medium Firm

Have you ever had an allergy to nuts? ☐ yes ☐ no
Have you ever had a reaction or an allergy to any of the following?
cosmetics *medicine* *iodine* *pollen* *waxing products* *hydroxy acids*
pumpkin *blueberries* *fragrance* *sunscreens* *soy* *sesame* *wheat* *coconut*
almond *walnut* *algae extract* *macadamia* *kukui* *hazelnut*

Do you have allergies to anything not listed above? ______________________________

Female Clients Only
Are you taking oral contraception? ☐ yes ☐ no
Are you pregnant or trying to become pregnant? ☐ yes ☐ no
Are you lactating? ☐ yes ☐ no

Male Clients Only
What is your current shaving system? ☐ electric ☐ wet shave
Do you experience irritation from shaving? ☐ yes ☐ no
Do you experience ingrown hairs? ☐ yes ☐ no

Questions to Discuss Every Visit
Are you currently having or due for your menstrual period? ☐ yes ☐ no
Have you started any new medication since your last visit? ☐ yes ☐ no
Have you taken antibiotics within the last 7 days? ☐ yes ☐ no
What are your skin care goals? ______________________________
____

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. **Please Note**: Accutane, Retin A, Renova and antibiotics can cause your skin to thin. Waxing and using exfoliants while using these products can tear and could result in scaring. Please do not withhold this Information when asked by your skincare therapist.

Client Signature ______________________ **Date** ______________