The Art *of* SkinCare

Consultation

Name: _____**Date:** _____

Address: _____**ZIP**_____

D.O.B._____/_____/_____ **Home Number:**_____ **Cell Number:**_____

Email Address: _____

Referred By: _____

1) Have you had a facial treatment before? Yes No

2) Do you have any specific skin conditions pertaining to your face or body? Yes No

   Explain_____

3) Have you been under the care of a dermatologist or physician within the past year?

   Yes No Explain_____

4) Have you had any recent facial surgeries or skin cancer? Yes No

5) Are you diabetic? Yes No

6) Have you had any chemical peels, microdermabrasion, Botox or facial fillers in the last month? Yes No
   Describe_____

7) Do you use Retin-A, Renova, Retinol or Alpha Hydroxy Products Yes No
   Describe_____

8) Are you using any acne medication including but not limited to Accutane? Yes No

9) Do you have any known allergies or skin sensitivity to any topical products? Yes No

10) What areas of concern do you have regarding your skin?

Breakouts/Acne	Wrinkles/Fine Lines
Dull/Dry Skin	Broken Capillaries
Hyperpigmentation (Brown Spots)	Flaky Skin
Uneven skin tone	Redness/Ruddiness
Rosacea	

Other_____

Female clients ONLY:

Are you pregnant? Yes No Lactating? Yes No

Do you experience claustrophobia? Yes No

I understand, have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to skin from treatments received.

Client Signature_____