

Name \_\_\_\_\_ Therapist \_\_\_\_\_

Address \_\_\_\_\_ apt/unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ zip \_\_\_\_\_

e-mail address \_\_\_\_\_ @ \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_

Birthday \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

YOUR HEALTH

1. Within the last year, have been under a dermatologist or physician's care? Yes No
2. Within the last nine months, have you undergone any surgery? Yes No
3. Have you had any health problems in the past or present? Yes No  
If yes, please specify \_\_\_\_\_
4. List any medications, supplements, diuretics, slimming tables etc. that you take regularly  
\_\_\_\_\_
5. Do you smoke? Yes No
6. Do you exercise regularly? Yes No
7. Do you follow a restricted diet? Yes No
8. Do you wear contact lenses? Yes No
9. Do you have metal implants, a pacemaker or body piercings? Yes No
10. Rate your level of stress on a scale of 1 to 4 (1= low stress, 4 = high stress) \_\_\_\_\_

YOUR SKIN

11. Do you have any special skin problems pertaining to you face and body? Yes No  
If yes, please explain \_\_\_\_\_
12. What skin care products are you currently using? Please circle  
Face: soap cleanser toner moisturizer masque exfoliator eye products  
Body: soap shower gel scrubs oil body moisturizer depilatory products self tanners

EXFOLIATION HISTORY

13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?  
Yes No in the last month? Yes No
14. Do you use Accutane, Retin A, Renova, Adaplene or any other prescription skin products?  
Yes No in the last 3 months? Yes No
15. Are you currently using any products that contain the following ingredients?  
Glycolic acid lactic acid any exfoliating scrubs any hydroxyl acid product  
vitamin A derivatives (i.e. retinol)



QUESTIONS TO DISCUSS EVERY VISIT

39. Are you currently having or due for your menstrual period?      Yes    No  
40. Have you started any new medication since your last visit?      Yes    No  
41. Have you had any recent dental x-rays?      Yes    No  
42. 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.

Client signature \_\_\_\_\_

TREATMENT / PRODUCT RECORD

Date \_\_\_\_\_ Treatment/products used \_\_\_\_\_  
Samples given \_\_\_\_\_ therapist \_\_\_\_\_

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*walk in ~ float out*