SKIN CARE CONSULTATION/NEW CLIENT INTAKE FORM

Name (print)_____ _Date_____

Address_____City_____St._____Zip_____

Cell Phone _____ Carrier_____Email_____

Emergency Contact_____ Phone_____ Relation_____

Date of Birth_____Occupation_____

Does your job require you to work outdoors for any period of time?_____ How long? _____

How did you hear about us? _____

What would you like to achieve from your treatment today? _____

What are your long term goals from your skin care therapy? _____

Please list any operations or serious illness in the past 5 (five) years:_____

_____

DO YOU SUFFER FROM ANY OF THE FOLLOWING ILLNESSES OR DISEASES? Please check mark all that apply

Epilepsy	____	Cardiac Disease	____	Photo Sensitivity	___
Lupus	____	Eczema	____		
Cancer	____	Bleeding Disorders	____	Clotting Disorders	____
Psoriasis	____	Keloid Scar	____		
Migraine	____	Cold Sores	____	Systemic Diseases	____
Diabetes	____	Hormonal Imbalance	___		
Lumps/cysts	___	Depression	____		

Have you ever had a skin care treatment/facial before? _____ When? _____ What? _____

What is your ethnic background? (Irish, Italian ETC.) _____ **MUST COMPLETE**

DESCRIBE YOUR SKIN?

Please circle all that apply!

Normal Oily Combination T-Zone Oily/Dry Freckled Sun Damaged Uneven/Blotchy

Mature Wrinkled Saggy Firm Large Pores Small Pores Acne Milia Blackheads

Occasional breakouts Rosacea Scarred Melasma Cystic Sallow Pigmented

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE?

Please circle one type number:

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

Do you have any special concerns pertaining to your face or body skin? _____

Specify_____

PLEASE CIRCLE

Have you ever had ..chemical peels……. laser resurfacing... Microdermabrasion…..Microneedling? DR._____

PLEASE CIRCLE

Do you use ...**prescription** Retin-A...Renova...Adapalene...Hydroxy Acid or Retinol vitamin A products?

Prescribing doctor_____ Strength of Retinol _____

Have you used any of these products in the last 3 months?_____ How Often _____

Have you used prescribed Acne medication? _____ When? _____ How long?_____ Which Drug?_____

Which skin care products are you currently using? ***Please list brand if known.***

Soap (body)_____ Shower Gel (body)_____

Toner _____ Body Lotions _____

Mask _____ Sunscreen (what # SPF?) _____

Eye Cream_____ Facial Cleanser _____

Night Cream _____ Day Moisturizer _____

Exfoliator _____ Makeup _____

Scrubs _____ Lip Care _____

Have you recently used self tanning products or treatments?_____Specify_____

Have you used any of the following hair removal methods in the past 6 (six) weeks? _____

Please circle all that apply!

Shaving Waxing Electrolysis Plucking Stringing Depilatories

Please circle all that apply!

Have you received any of the following injectablles ? Date?_____Dr. _____

BOTOX Restylane Juvaderm Voluma Radiesse Other_____

PLEASE LIST ANY MEDICATION S OR SUPPLEMENTS YOU ARE TAKING AT THIS TIME OR IN THE PAST 3 MONTHS

_____

_____

What number SPF do you use on your face? _____ How often/when? _____

What number SPF do you use on your body? _____ How often/when? _____

What area of concern do you have regarding your:

SKIN: **Please circle all that apply!**

Breakouts/acne Blackheads/whiteheads Excessive oil/Shine Rosacea Broken capillaries

Redness/rudiness Sun spot/liver spots/brown spots Uneven skin tone Wrinkles/fine lines Dehydrated

Dull/dry skin Flaky skin Other: _____

EYES: **Please circle all that apply!**

Dehydrated Wrinkles Puffiness Dark circles

LIPS: **Please circle all that apply!**

Dehydrated Wrinkles Chapped/cracked

Have you ever had an allergic reaction to any of the following? Please circle all that apply.

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs Fragrance Shellfish

Latex Drugs Other _____

PLEASE explain reaction:_____

_____

Do you smoke? _____ How many per day? ___ How Long?_____

Do you drink alcohol? ____ How many glasses per day? _____

How would you rate your diet/eating habits? **Please circle one:**

POOR FAIR MODERATE EXCELLENT

Do you eat fish regularly? _____ How much red meat do you eat? _____

Do you eat five (5) portions of fruit and vegetables daily? _____

How many dairy products do you consume in one week? _____

How would you rate your health at this moment? _____Why?_____

Please add any more information below if you feel we should know more about you, your lifestyle and your desired results from our treatments. _____

_____

FEMALE CLIENTS ONLY

Are you taking oral contraceptives? ____ Specify _____

Any recent changes to or from your contraceptive treatment? _____ Specify _____

Are you pregnant or trying to become pregnant? _____ If YES When do you plan on it?_____

Are you lactating? _____ Any Menopause problems? _____ Specify _____

Are you undergoing hormone therapy replacement? _____ Dr._____Specify _____

MALE CLIENTS ONLY

What is your current shaving system? **Please circle one.** Dry shave Wet shave Electric shave

Do you experience irritation from shaving? _____ In grown hairs? _____ Flakey skin?_____

I understand, have read, and completed this questionnaire truthfully. I agree 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 contraindications, and /or irritation to the skin from treatments received. The treatments I receive here are voluntary, and I release Skin Serenity Spa, and /or skin care therapist from liability, and assume full responsibility thereof.

Parent/Guardian signature if under 18 years old_____ Date_____

Client Signature_____ Print _____ Date_____

Technician Signature_____Print_____ Date _____