Please complete the information requested so that I may provide you with the best treatment possible. **All information is strictly confidential.**

Date: _______________

First Name: _____________________Last Name:________________________________

MO/Day of Birth: ____________Age:_______ Occupation:________________________

Home Address: ____________________City:________________State:_______Zip:______

Email Address: ___________________________________ Phone:_____________________

Interested in receiving my monthly newsletter with skin care tips and monthly promotions? ☐Yes ☐No (email address will not be shared)

Emergency Contact Name/ Phone:____

Whom may I thank for referring you?____

Which of the following best describes your skin type? (Please <u>circle</u> one type) If you are completing this electronically, please put an "X" after the number.

I	Always Burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin
VI	Black skin

What is your ethnicity?____

Natural Eye color: ☐Blue ☐ Hazel ☐Green ☐Gray ☐ Brown ☐ Black

Natural Hair Color: ☐Blond ☐Red ☐Lt. Brown ☐ Med. Brown ☐Dk. Brown ☐ Black ☐Gray/Silver ☐White

Describe your skin <u>(check all that apply)</u>: ☐ Normal ☐Dry ☐Oily

☐T-Zone/Combination ☐Thick ☐Thin ☐Firm ☐Acne ☐Blackheads
☐ Cysts ☐Breakouts ☐Acne-scarred ☐Large pores ☐Rosacea ☐Eczema
☐Freckled ☐Hyperpigmentation (dark spots) ☐ Hypopigmentation (white spots)
☐Uneven/blotchy ☐Mature ☐ Wrinkled ☐Patchy dryness ☐Sallow (yellowish-dull)
☐capillaries ☐Sensitive ☐Resilient

MEDICAL HISTORY

Are you currently under the care of a physician? ☐Yes ☐No
If yes, what for? ____

____

Do you have any of the following medical conditions **(please circle all that apply below).**

Cancer Diabetes high blood pressure herpes arthritis frequent cold sores
HIV/AIDS Asthma Skin disease/skin lesions seizure disorder hepatitis
Hormone imbalance thyroid imbalance blood clotting abnormalities

Do you have any other health problems or medical conditions? Please list:
____

Are you currently taking any medications for this condition? ___________________
When was your last facial?__________________
Any specific issues with your skin that you would like to improve?_______________
Have you ever had skin cancer? ☐Yes ☐No If yes, where and when?___________
Do you use products with Retinol (vitamin A)? ☐Yes ☐ No
Have you ever used Accutane for acne? ☐Yes ☐No If yes when?________________
Acne medications prescribed or over-the-counter (gels, creams)? ☐Yes ☐No
If yes, which product and when was the last time you used it?_____________________
Have you ever used products with AHA or BHA acids? (glycolic, salicylic) ☐Yes ☐No
If yes, when did you use it last?____
Have you ever had an allergic reaction to Aspirin? ☐Yes ☐ No
Mushrooms? ☐Yes ☐ No Papaya ☐Yes ☐ No
Do you wear contact lenses? ☐Yes ☐No Do you smoke? ☐Yes ☐No
Which skin care line/brand(s) are you presently using?

____

Female Clients:

☐Birth Control Pills ☐Hormones
Are you pregnant or nursing**?** ☐Yes ☐No

Cancellation Policy: A charge of $65 may be imposed for no shows or appointments cancelled within 24 hours of your scheduled appointment. If you have booked a double treatment (facial & back treatment) and need to reschedule please give 48 hour notice.

I understand your cancellation policy and that the services offered are not a substitute for medical care, and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in providing better service and is completely confidential.

Client Signature________________________________**Date**______________