CONFIDENTIAL SKIN HEALTH INTAKE FORM

PLEASE PRINT CLEARLY

Today's Date: _____

First Name: _____ Last Name: _____ Date of Birth: __/__/_____

Street _____ Apt # _____ City _____ State _____

Phone: Home (____) _____-_____ Work: (____) _____-_____ Mobile: (____) _____-_____

Primary Care Physician: _____

Dermatologist: _____

Emergency Contact: _____

Your Occupation: _____

Referred by: _____

☐ Friend ☐ Mailer ☐ Walk/Drive-by ☐ Yellow Pages ☐ Gift Certificate ☐ Other

Esthetician Name: _____

1. Is this your first visit to the salon/spa? ☐ Yes ☐ No
2. What is the primary reason for your visit today? _____
3. What special areas of concern do you have? Please check all that apply.

☐ Acne Management	☐ Enlarged Pores	☐ Scarring
☐ Acne Scarring	☐ Fine Lines and Wrinkles	☐ Stretch Marks
☐ Age Management	☐ Hair Removal	☐ Sun Damage
☐ Age Spots	☐ Pigmentation	☐ Other
☐ Broken Capillaries	☐ Rejuvenation	

Please explain your concerns in detail here: _____

_____

_____

4. Have you ever had a facial treatment before? ☐ Yes ☐ No
   If yes, when was your last treatment? _____
5. How would you describe your experience? ☐ Positive ☐ Negative
   Additional Comments: _____

_____

6. Have you ever had any of the following? If yes, please state the date of last treatment next to all that apply.

☐ Microdermabrasion
If yes, date of last treatment. _____

☐ Hair Removal
☐ Electrolysis ☐ Laser ☐ IPL
☐ Waxing ☐ Other
If yes, date of last treatment.
_____

☐ Botox® Injections
If yes, date of last treatment. _____

☐ Collagen Injections
If yes, date of last treatment. _____

☐ Restylane® Injections
If yes, date of last treatment. _____

☐ Cosmetic Fillers
Please list all here: _____

_____

If yes, please state date of last treatment.
_____

☐ Facial or Cosmetic Surgery
If yes, please describe and state date of last procedure. _____

_____

☐ Chemical Peels
If yes, date of last treatment. _____

☐ Natural Peels
If yes, date of last treatment. _____

☐ Laser Skin Resurfacing
If yes, date of last treatment. _____

☐ Massage
If yes, date of last treatment. _____

☐ Body Treatments
If yes, date of last treatment. _____

☐ Permanent Makeup/Tattooing
If yes, date of last treatment. _____

☐ Other
Please list any other cosmetic procedures or injections you have had here:

_____

_____

Please state date of last treatment. _____

_____

CLIENT CONSULTATION FORM: SKIN TREATMENTS

Date:
Name:
Address:
City: State: Zip:
Phone: Cell:
E-mail:
Referred by:
Main reason for visit:

Have you had facials before? Yes No
Do you have any skin concerns?
Circle those that apply below:
Aging Dryness Redness Wrinkles Sun Damage
Acne Blemishes Oiliness Peeling Rough Texture
Pigmentation (dark or light discolored areas)

Do you have any allergies? Yes No
Please list:
Are you allergic to any ingredients? Yes No
Please list:
Have you recently seen a dermatologist? Y N
Have you had any recent surgeries, laser procedures, or strong exfoliation treatments? Y N
Type of Treatment: When?
Please list any medications you take:
Do you have any health issues or skin conditions? Y N
Please list:
What facial care products do you use?
Circle those that apply below:
Soap Cleanser Toner Moisturizer Sunscreen Mask
Night cream Exfoliant, Scrub, or Peeling product
Favorite product line:

SKIN ANALYSIS CHART

Skin Type: Dry Normal Combination Oily Acne

Esthetician: **Date:**

Conditions:	**Facial Area:**
Dehydrated	
Aging	
Wrinkles	
Sun damage	
Redness	
Couperose	
Pigmentation:	
Hyper or hypo	
Comedones (open or closed)	
Milia	
Hyperkeratinization (rough, cell build up)	
Psoriasis	
Other:	

Conditions:	**Facial Area:**
Poor Elasticity	
Rosacea	
Sensitive	
Oiliness	
Acne - Grade: 1 2 3 4	
Cysts	
Papules	
Pustules	
Asphixiated	
Sunburn	
Moles	
Scarring	

Contraindications:

SKIN CARE TREATMENT RECORD

Date **Type of Treatment** **Esthetician**

Notes/Comments:

	Products Used:	**Products recommended**	**Products purchased**
Cleanser:			
Exfoliant:			
Mask			
Massage			
Toner			
Serum			
Eyes/lips			
Moisturizer, Sunscreen			
Other:			

Date **Type of Treatment** **Products recommended** **Products purchased** **Esthetician**

Notes/Comments: