Skin Care

Client Information

Name:_____DOB:_____

Street Adress: _____

City:_____State:_____Zip Code:_____Phone: _____

Email:_____

Emergency Contact:_____Relationship:_____Phone: _____

How did you her about us? (circle one) Our Website Sign Brochure Event

Woman's Journal Google Facebook Twitter Yelp Newsletter

Family/Friend Instagram Gift Certificate Other_____

Questions (please Circle)

1. Do you smoke?..... Yes / No
2. Are you under a dermatologist/doctor's care for skincare?..... Yes / No
3. Have you ever had skin cancer?.....Yes / No
4. Do you wear contact lenses?..... Yes / No
5. Are you pregnant?..... Yes / No
6. Are you currently taking birth control pills?..... Yes / No
7. Are you currently on hormone replacement?..... Yes / No
8. Have you ever used Accutane?..... Yes / No

   If yes, how long ago?_____

9. Do you have allergies to cosmetics, food, or drugs?..... Yes / No
10. Do you have any sensitivity to any scents/aromatherapy?..... Yes / No
11. Are you currently taking any medications?..... Yes / No

    If yes, please specify perscription (orally or topically)_____

12. Any specific skincare concerns? example: (oily, dry, delicate)

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13. Please circle if you are affected by/have any of the following:

Asthma Skin Disease Metal implants Cardiac Issues Hepatitis

Pacemaker Lupus Claustrophobia Herpes/Fever Blisters

Sinus Issues High Blood Pressure Eczema Epilepsy

Immune Disorder Headaches

I have completed this form to the best of my knowledge. I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational and cosmetic purposes only and not diagnostically perscriptive by nature. I understand that the information herein is to aid the therapist in safely giving better services and is completely confidential.

Signature:_____Date:_____