Erica Munz, L.E. | The Zen Den Body and Skincare | 1315 Main Ave Suite 220

Client Consultation & Confidential Health History Form

Date:______________________________

Name:____ Date of Birth:_____________________________

Address:____

Cell Phone:____________________________________Home Phone:_______________________________________

E-mail address:____

Employer:___________________________________Occupation:____

Does your job require that you work outdoors? N_____ Y_____

How did you hear about us/ who may we thank for referring you:____

What would you like to achieve from your treatment today?

____

Your Skin Care

1) Have you ever had a facial treatment before? N_____ Y _____, when?___________________

2) 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

3) What areas of concern do you have regarding your:

Skin: (Please check any that apply and explain)

Breakouts/acne	______	Uneven skin tone	______
Blackheads/whiteheads	______	Sun Damage	______
Excessive oil/shine	______	Wrinkles/fine lines	______
Rosacea	______	Dull/dry skin	______
Broken capillaries	______	Flaky skin	______
Redness/ruddiness	______	Dehydrated	______

Sun spot/liver spot/brown spot_____ Other____

Eyes:

Dehydrated_____ Wrinkles_____ Puffiness_____ Dark Circles____

Other:_______________

Lips:

Dehydrated_____ Cracked/Chapped lips______ Other:_________________

4) Do you have any special skin problems or concerns pertaining to your face or body? N_____ Y______
specify:____

5) Have you ever had chemical peels, laser or microdermabrasion in the last month? N___Y____, when:____

6) Do you use Retin-A, Renova, AHAs or Retinol/Vit A derivative products? N_____ Y____

describe:____

7) Do you smoke? N_____ Y_____

8) How often do you drink: Never_____ Sometimes_____ Often______, ____x a week

9) What is your stress level? High_____ Medium_____ Low_____

10) Do you have Hyperpigmentation (darkening of skin) or Hypopigmentation (lightening of skin) or mark after physical trauma? N___ Y___, describe:____

11) List your daily consumption of: Water_________________ Caffeine__________________

12) Do you wear contact lenses? N_____ Y_____

13) Do you have any metal implants or wear a pacemaker? N____ Y____

14) Have you used an acne medication? N_____ Y_____, when?____________ which drug?_____________________

15) What skin care products are you currently using? (List brand where known)

Soap____ Shower Gels__________________________________

Toner_______________________________________ Body Lotions_________________________________

Cleanser_____________________________________ Sunscreen____________________________________

Eye Product__________________________________ Exfoliator____________________________________

Mask_______________________________________ Night Cream__________________________________

Day Moisturizer_______________________________ Other____

Makeup Products____

16) Are you on any medications? N____ Y____,

specify:____

17) Have you had any recent tanning bed or sun exposure that changed the color of your skin? N___ Y___

specify:____

18) Have you used any hair removal methods in the past week? N_____ Y____

18b) Do you experience ingrowns? N_____ Y______, where:____

19) Have you ever had an adverse reaction after using any skin care products? (Please circle)

RashIrritation Peeling Sun Sensitivity Breakout

20) Have you ever had an allergic reaction to any of the following? (Please circle any that apply & explain) If Yes, please explain:____

Cosmetics	AHAs	Medicine	Aspirin
Shellfish	Animals	Latex	Sunscreens
Iodine	**Essential Oils**	Other____	

21) Do you get cold sores? N_____ Y_____

22) Do you wear SPF on your face & body? N____ Y_____, how strong:_________ when:______________________

23) Have you experienced Botox, Restylane or Collagen injections? N_____ Y_____

specify:____

Female Clients Only:

Are you on birth control? N_____ Y_____,

specify:____

Any recent changes to or from your birth control? N____ Y____ If so, what and when:_________________________

Are you pregnant or trying to become pregnant? N____ Y_____

Are you experiencing menopause? N_____ Y_____
Are you undergoing any hormone replacement therapy? N_____ Y______

Male Clients Only:

What is your current shaving system? Wet shave_____ Electric_____
Do you experience irritation from shaving? N_____ Y_____
Ingrown hairs? N_____ Y______

Future Appointments/Contact:

May I call________ text________ or email________ to confirm future appointments? Or None____
May I contact you via mail/email about future promotions/discounts and news? Y_____ N_____

I understand, have read and completed this questionnaire truthfully. I agree that 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 this skin care professional from liability and assume full responsibility thereof.

Client Signature:____
Date_________________________________