Integrated Aesthetics

Name: _____Phone: _____ d.o.b: _____
Address: _____City: _____State: _____Zip:_____
E-mail: __If you would like to be added to newsletter_____ Referred by:_____

Your Health

Are you under the care of a dermatologist? Name: _____
Have you been diagnosed with, please circle: epilepsy / diabetes / thyroid disorder / cancer / high blood pressure / arthritis / seizure disorder / hepatitis / hormone imbalance / blood clotting abnormalities / active infections
Have you undergone plastic surgery in the past year? N / Y **Please circle your stress level**: low 1 – 2 – 3 high
Do you smoke or live with a smoker? N / Y **Do you exercise regularly**? N / Y
Follow a restricted diet? N / Y **Do you wear contact lenses**? N / Y
Please disclose medications/oral antibiotics/vitamins/diuretics. _____

Your Skin

Circle products are you using currently: soap / cleanser / toner / day moisturizer / spf / masque / eye crème / bleaching agents / night moisturizer / depilatory products / self tanners / Vitamin A or C / exfoliators / topical or oral antibiotic / benzoyl peroxide / salicylic acid / AHA's / hydroquinone / Accutane **Are you**: dry / normal / oily
Skin Type: **I** always burn, never tan: **II** usually burn, tan with difficulty **III** sometimes mild burn, tan about average
IV rarely burn, tan with ease **V** brown skinned people, don't burn but tan **VI** black skinned people, never burn, but tan

Treatment History

Please circle if you had a: facial, chemical peel, facial surgery, waxing, microdermabrasion, laser, IPL, Botox or dermal fillers in the last month
Are you prone to cold sores? N / Y

Hydration

How much water do you consume daily? _____ **Do you sunbathe or use tanning beds**? N / Y
Are you prone to: flakiness / tightness / obvious dryness / scaliness /eczema / psoriasis / keloid scarring

Vascularity

Do you burn easily in moderate sunlight? N / Y **Do you blush easily when nervous**? N / Y
Do you have a tendency to redness? N / Y **Do you suffer sinus problems**? N / Y

Sebaceous Activity

Do you experience oily shine during the day? N / Y **Do you experience skin breakouts**? blackheads/papules/pustules/clots/milia

Nerve Activity

Do you ever experience a burning, itching sensation on your skin? N / Y **Is your skin:** reactive **/** sensitive
What is your pain threshold? Please circle: low / medium / high **Have you ever experienced claustrophobia**? N / Y
Are you allergic to: medicine / iodine / pollen / hydroxy acids / sunscreens / sulfur / nuts / aspirin / latex / lidocane / hydroquinone / milk / apples / citrus / grapes / aloe vera / mushrooms / alcohols / tropical fruit / other: _____

Female Clients Only

Are you taking oral contraception? N / Y **Are you taking HRT?** N / Y
Are you pregnant or trying to become pregnant? N / Y **Lactating**? N / Y **Have or due for your menstrual cycl**e? N / Y

Male Clients Only

What is your current shaving system? electric / blade
Do you experience irritation from shaving? N / Y **Do you experience ingrown hairs**? N / Y

Skin Care Goals

Please rank top 3 concerns: ___relaxation ___hyperpigmentation ___oil/acne ___redness
___laxity ___fine lines ___dryness ___roughness ___thin

I understand that my participation in my skin care treatments will determine the outcome. It is important that I adhere to my home care regimen that has been recommended to me. I have stated all medical conditions that I am aware of and I will update Integrated Aesthetics of any changes to my health status. I acknowledge that the therapist will not be responsible for any injury arising because of an unreported condition or concern. I understand the therapist is neither trained nor licensed to provide medical treatment, diagnose, prescribe drugs or medication. I acknowledge that these treatments are not a substitute for medical examination or diagnosis. I understand that with any treatment certain risks are involved & that complications or side effects from known or unknown causes could occur. I freely assume these risks I hereby give my consent voluntarily & release Integrated Aesthetics from any claims, representations or guarantees about specific results. I will inform my practitioner of any complications or concerns I may have as soon as they occur. By my signature, I acknowledge having read & understood the precautions. I consent to receive indicated treatments.

_____ _____
Client Signature **Date**