CLIENT CONSULTATION

Client Name _____
last first

Client Address _____ apt/unit _____

City _____ State _____ Zip _____

Email _____ @ _____

Telephone: Home _____ Work _____

Age ■ under 21 ■ 21-30 ■ 31-40 ■ 41-50 ■ 51-60 ■ 60+

YOUR HEALTH

1 Within the last year, have you been under a dermatologist or other physician's care? ■yes ■no

2 With in the last nine months, have you undergone any surgery? ■yes ■no
If yes, please specify

3 Have you had any health problems in the past or present? ■yes ■no
If yes, please specify

4 List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly
_____

5 Do you smoke? ■yes ■no

6 Do you exercise regularly? ■yes ■no

7 Do you follow a restricted diet? ■yes ■no

8 Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) ____

9 Do you have any special skin problems pertaining to your face or body? ■yes ■no

10 What skin care products are you currently using?

face: ■ soap ■ cleanser ■ toner ■ moisturizer ■ masque ■ exfoliator ■ eye products

body: ■ soap ■ shower gel ■ scrubs ■ oil ■ body moisturizer ■ depilatory products ■ self tanners

EXFOLIATION HISTORY

11 Have you ever had chemical peels, laser, microdermabrasion or any resurfacing treatments? ■yes ■no

in the last month? ■yes ■no

12 Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? Any injections? ■yes ■no

in the last 3 months? ■yes ■no

13 Are you currently using any products that contain the following ingredients?

■ glycolic acid ■ lactic acid ■ any exfoliating scrubs ■ any hydroxy acid product ■ vitamin A derivatives (i.e. retinol)

MOISTURE HYDRATION

14 How much plain water do you consume daily?____

15 How many alcoholic beverages do you consume weekly?_____

16 Do you ever experience these conditions on your skin?

■ *flakiness* ■ *tightness* ■ *obvious dryness*

17 What spf sunscreen do you use on your face?_____body?_____

18 Do you sunbathe or use tanning beds? ■yes ■no

CAPILLARY ACTIVITY

19 Do you burn easily in moderate sunlight? ■yes ■no

20 Do you blush easily when nervous? ■yes ■no

21 Do you have a tendency to redness? ■yes ■no

22 Do you suffer from sinus problems? ■yes ■no

OIL SECRETION

23 Do you ever experience oily shine during the day?

■*yes* ■*no* ■*occasionally*

24 Do you ever experience skin breakouts?

■*yes* ■*no* ■*occasionally*

NERVE ACTIVITY

25 Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) ■yes ■no

26 Do you ever experience a burning, itching sensation on your skin? ■yes ■no

27 Have you ever had a reaction to any of the following?

■ cosmetics ■ medicine ■ iodine ■ pollen ■ fragrance ■ sunscreen ■ seaweed ■ aspirin ■ iodine ■ other ■ food ■ hydroxy acids ■ animals

FEMALE CLIENTS ONLY

28 Are you taking oral contraception or hormone replacement therapy? ■yes ■no

29 Are you pregnant and seeing changes in your skin? ■yes ■no

30 If yes, what changes are you experiencing?
_____
_____

MALE CLIENTS ONLY

31 What is your current shaving system?
■ electric ■ wet shave

32 Do you experience irritation from shaving?

33 Do you experience ingrown hairs? ■yes ■no

34 What are your skin care goals? ■yes ■no
_____
_____
_____
_____