Skin Care Intake

Client Name:____________________________ DOB:____________________________

Do you have any allergies (including food)? ____

Please list all supplements, medications, or recent surgeries: ______________________________________
____
____
____
____

Please list any health conditions you are currently experiencing: __________________________________
____
____
____

Have you ever taken or currently taking: ( ) Retin A ( ) Accutane

Are you currently taking: ( ) Oral Antibiotics ( ) Topical Antibiotics

If yes, what is the name of the antibiotic: ____

Are you currently: ( ) Pregnant ( ) Nursing

Do you smoke? ___Y ___N

How many hours of sleep do you get a night? ______________

How many 8oz. glasses of water do you drink each day? ______________

How much caffeine and\or alcohol do you consume each day? Caffeine _______ Alcohol ______

What is your level of stress? Low 1 2 3 4 5 6 7 8 9 10 High

How often do you exercise? ____

How much UV exposure do you get on average (sun, tanning beds, driving)? ________________________

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Do you suffer from any of the following:
Please mark with an x all that apply

	Scars		Stretch marks		Hyperpigmentation
	Acne		Dehydration		Eczema
	Cellulite		Blackheads		Milia
	Vein\circulation problems		Oiliness		Rosacea
	Whiteheads		Psoriasis: Where?		Hypersensitive skin
	Other:		Other:		Other:

Have you ever received any of the following treatments?

	Treatment	**When?**
	Facial	
	Microdermabrasion	
	Laser Surgery	
	Chemical Peels	
	Waxing	
	Lash/Brow Tint	
	Laser Hair Removal	
	Vein Treatments	
	Botox/Fillers	

Please select the one that applies to you:

	I never tan, I always burn		I tan with difficulty, usually burn
	Average tanning, sometimes burn		Easily tan, rarely burn
	I never burn		

Natural Hair Color? ______________________________

Natural eye color? _______________________________

Skin tone (i.e. pale, olive)? ________________________