Facial, Waxing, & Sugaring Intake

Name			
Address			
City		State	Zip Code
Email		Specials ☐	Reminders ☐
Cell Phone #	Cell Carrier	Home Phone #	
Date of Birth	☐ Under 21 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 60+		
How did you hear about us?			

Health

1. Within the last year, have you been under a dermatologist's or other physician's care? ☐ yes ☐ no
2. Within the last nine months, have you undergone any surgery? ☐ yes ☐ no
   If yes, please specify:
3. List any medications, supplements, vitamins, diuretics, slimming tablets, topical skin lotions, ect.
4. Do you smoke? ☐ yes ☐ no
5. Do you exercise regularly? ☐ yes ☐ no
6. Do you follow a restricted diet? ☐ yes ☐ no
7. Do you wear contact lenses? ☐ yes ☐ no
8. Do you have metal implants, a pacemaker or body piercings? ☐ yes ☐ no
9. Are you pregnant or lactating? ☐ yes ☐ no
10. Always allow five days for menstrual cycle. You should avoid hair removal 2 days before and 2 days after your cycle.
11. Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress)

Skin

12. Do you have any special skin problems pertaining to your face or body? ☐ yes ☐ no
    If yes, please specify
13. 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

Please Turn Over

Exfoliation History

14. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?
    ☐yes ☐no In the last month? ☐yes ☐ no
15. Do you use Accutane, Retin-A, Renova, Tazorac, Adapalene or any other prescription skin products?
    ☐ yes ☐no In the last month? ☐yes ☐ no

16. Are you currently using any products that contain the following ingredients?
    ☐ glycolic acid ☐ lactic acid ☐ any exfoliating scrubs ☐ any hydroxyl acid product
    ☐ vitamin A derivatives (i.e., Retinol)

Moisture Hydration

17. How much plain water do you consume daily?
18. How many alcoholic beverages do you consume weekly?
19. Do you ever experience these conditions on your skin? ☐flakiness ☐tightness ☐obvious dryness

20. What SPF sunscreen do you use on your face? body?
21. Do you sunbathe or use tanning beds? ☐ yes ☐ no

Capillary Activity

22. Do you burn easily in moderate sunlight? ☐ yes ☐ no
23. Do you blush easily when nervous? ☐ yes ☐ no
24. Do you have a tendency to redness? ☐ yes ☐ no
25. Do you suffer from sinus problems? ☐ yes ☐ no

Oil Secretion

26. Do you ever experience oily shine during the day? ☐ yes ☐ no
    If yes, how long after you wash your face do you notice the shine?

27. Do you ever experience skin breakouts? ☐ yes ☐ no ☐ occasionally

Nerve Activity

28. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) ☐ yes ☐ no
29. Do you ever experience a burning, itching sensation on your skin? ☐ yes ☐ no
30. Have you ever experienced claustrophobia? ☐ yes ☐ no
31. What type of massage pressure do you prefer? ☐ light ☐ medium ☐ firm
32. Have you ever had a reaction to any of the following?
    ☐ cosmetics ☐ medicine ☐ iodine ☐ pollen ☐ food ☐ hydroxyl acids ☐ animals
    ☐ fragrance ☐ sunscreens ☐ other

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client signature: ______________________________ Date: ______________