Name: _____ **Date:** _____

Have you had cosmetic surgery/non-surgical procedure? Yes___ No___

When?_____ Doctor _____ What Type?_____

Is this your first facial? Yes__ No__

If no, when was your last treatment? Month ___ / Year___

Are you currently under the care of a dermatologist? Yes__ No__

What is the primary reason for your visit today?_____

_____

Do you experience any of the following? (mark all that apply):

__ Blackheads __Whiteheads __ Acne __ Excessive Oiliness __ Excessive Dryness __ Wrinkles
__ Acne __Fine Lines __ Dehydration __ Psoriasis __ Eczema __ Dark Circles __ Under-eye Puffiness
__ Face Puffiness __ Rosacea __ Sensitivity __ Broken Capillaries __ Redness __ Scars __ Skin Cancer
__ Freckles __ In-grown Facial Hair __ Hyperpigmentation/Dark Spots __Swollen Lymph Nodes
__ Severely Chapped Lips __ Other

If Other, please explain: _____

Please elaborate on any concerns that require more detail: _____

_____

Please list facial products used:

Cleanser _____ Toner_____ Moisturizer_____
Night Cream_____ Make up_____ Makeup Remover_____
Exfoliant (scrub. Enzyme. Etc.) _____Mask_____Toner_____
Serum _____ Sunscreen _____ Night Cream_____
Other _____

If marked **Yes** for makeup. How often do you wash your brushes or sponges?

_____

If other, please specify:

_____

Have you ever received any of the following?

__Microdermabrasion When:_____ Area:_____ Type:_____

__Lasers When:_____ Area:_____ Type:_____

__Injections/Injectables When:_____ Area:_____ Type:_____

__Waxing When:_____ Area:_____ Type:_____

__Peels When:_____ Area:_____ Type:_____

-If marked Yes for Peels, did your skin flake or was there down time? Yes__ No__

__Other Please Specify: _____

When:_____ Area:_____ Type:_____

Do you use any of the following currently or in the past?:

Accutane Yes__ No__ Within the past 12 months__

Retin-A Yes__ No__ Within the past month__

HRT Yes__ No__

Birth Control Yes___ No__

If you have used any other oral or topical skin medications in the past 6 months, please specify and last time uses:

What:_____ Last time used:_____

Check any health conditions which you are now experiencing:
HIV___ Diabetes___ High/Low Blood Pressure___ Cancer___ Pregnant___ Thyroid___
Eczema/Psoriasis___ Hepatitis____ Respiratory other than Asthma ____ Herpes Simplex___
Dysautonomia____ Epilepsy_____ HIV/AIDS___

Do you have any mental impants, pins, or plates? __Yes __No

Do you have a pacemaker? __Yes __No

Have you had surgery (including cosmetic) or any non-surgical procedures? __Yes __No

If yes, please specify what was done & when?
_____

Do you have any permanent makeup or tattoos? __Yes __No

Are you currently taking other non-skincare medications or supplements? __Yes __No

If yes, please specify:
_____

How often do you exercise? Rarely Occasionally Frequently Daily

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

How many hours of sleep do you usually get per night? 0-3 3-6 6-9 9+

How many oz. of water do you consume per day? ___oz

How much caffeine do you consume per day? _____ Per week? _____

Do you Smoke? __Yes __No

Sun/UV Exposure: *Never* *Light* *Moderate* *Heavy*

Do you wear sunscreen/sunblock? __Yes __No

Do you purposefully go tanning? __Yes __No

Is there any area you would like your therapist to avoid today? __Yes __No

If yes, please specify where: _____

List any drug/food allergies or reactions (please specify): _____

_____

List all medications/supplements you are currently taking: _____

_____

_____

Please use the space provided for any additional information you would like your therapist to know regarding your treatment today:

_____

_____

_____

_____

Your Signature below indicates you have provided accurate information. Your therapist uses all natural edible organic food products and essential oils in their facials. It is mandatory that you disclose any food allergies prior to the treatment. We cannot be held responsible for any preventable reactions.

Client Signature: _____ **Date**:_____

Client Printed Name: _____