SKIN SENSE®
a day spa
BRINGING BALANCE TO LIFE™

# Client Information Form

Thank you for choosing to trust Skin Sense with your skin.
Please answer the following questions so that our Estheticians may have a better understanding of your general health and lifestyle, enabling us to accurately analyze and access your unique skin care needs.

## Personal Information

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Date of Birth: _____

Email Address: _____

## Health History

What type of work do you do? _____
Have you seen a Dermatologist in the past year? Yes _____ No _____
If yes, list Dermatologist's name, contact information and reason for visit: _____

_____

Are you currently taking any medications? Yes _____ No _____
If yes, please list: _____

_____

What is your genetic background? (This is for skincare analysis only) _____

How is your general health? Excellent _____ Good _____ Fair _____ Poor _____

Please circle the following conditions you have/had experienced:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| hypertension | cold sores | anemia | cancer | seizures | headaches | fainting | contacts |
| metal plate | hernia | lupus | thyroid disorders | eating disorder | asthma | claustrophobia | epilepsy |
| diabetes | stroke | irregular pulse | high cholesterol | hear attack | hepatitis | varicose veins | |
| tooth fillings | high/low blood pressure | | | | | | |

Do you take nutritional supplements? Yes _____ No _____
Do you exercise? Yes _____ No _____
Do you have a tendency to scar? Yes _____ No _____

**Allergies:**
Have you ever had an allergic reaction to any of the following:
Aspirin or Salicylates Yes _____ No _____
Milk Yes _____ No _____
Apples Yes _____ No _____
Citrus Yes _____ No _____
Grapes Yes _____ No _____
Ingredients in skincare products Yes _____ No _____
Fish, marine or iodine allergies Yes _____ No _____
Latex Yes _____ No _____
If checked yes to any of the above, please explain _____

*Please list any other known allergies* _____

*Have you ever had Herpes Simplex?* *Yes* _____ *No* _____

*If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax®(Acylivor) or Abreva?* _____

*Are you being treated for Hepatitis?* *Yes* _____ *No* _____

*Female clients only:*

*Are you on hormone replacement therapy?* *Yes* _____ *No* _____

*Are you presently taking birth control pills?* *Yes* _____ *No* _____

## Skincare History

*Are you currently having skin treatments?* *Yes* _____ *No* _____

*If yes, what type of treatment(s)?* _____

*Please circle if you are presently experiencing or have experienced in the past:*

*Skin Cancer* *Broken Capillaries* *Dermatitis* *Treatment Reactions* *Keloid Scarring* *Hypopigmentation*
*Acne* *Hyperpigmentation* *Rosacea*

*Please circle if you have or have you had any of the following in the last 14 days:*

*Facial Cosmetic Surgery* *Chemical Exfoliation (Peels)* *Botox Injections* *Extractions* *Collagen Injections*
*Permanent Cosmetics* *Fillers* *Light Treatments* *Waxing* *Laser Hair Removal*
*Laser Resurfacing* *Microdermabrasion* *Hair Treatments (perm, color, etc.)*
*Other* _____

***Home Care:***

*Please circle the skincare products are you currently using at home:*

*Cleanser* *Vitamin C* *Toner* *Exfoliants/Scrubs* *Moisturizer* *Specialty Products* *SPF* *Mask*

*Please circle if you are using or have used any of the following:*

*Benzoyl Peroxide (BP)* *Glycolic Acid (AHA)* *Lactic Acid (AHA)* *Resorcinol* *Salicylic Acid (BHA)*
*Sulfur* *Vitamin C* *Vitamin A* *Hydrocortisone (HC)* *Hydroquinone (HQ)*

*Please circle if you have been prescribed the following products:*

*Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)* *Adepalene (Differin®)* *Azelaic Acid (Azelex®, Finacea ™)*
*Tazarotene (Tazorac®)* *Isotretinoin (Accutane)* *Triluma*
*Metrogel* *Other* _____

***Sun Protection:***

*Do you use a sunscreen?* *Yes* _____ *No* _____

*What level of protection?* _____

*Do you sunbathe or participate in outdoor activities?* *Yes* _____ *No* _____

*Do you tan in a tanning booth?* *Yes* _____ *No* _____

*Have you tanned in a tanning booth in the last 14 days?* *Yes* _____ *No* _____

*Have you had any direct sun exposure in the last 10 days?* *Yes* _____ *No* _____

*When exposed to the sun do you (Please circle one)*

*Always burn, never tan* *Always burn, sometimes tan* *Sometimes burn, sometimes tan* *Always tan*

*Do you feel your skin is sensitive?* *Yes* _____ *No* _____

*What skin conditions do you want to improve? (Please circle all that apply)*

*Acne and/or breakouts* *Rosacea* *Facial Scarring* *Uneven Tone* *Hyperpigmentation (freckles, age spots)*
*Enlarged Pores* *Dehydration* *Uneven Texure* *Oily* *Hypopigmentation*
*Fine Lines and Wrinkles* *Sun Damage* *Other* _____

*Is there any other necessary information your skincare specialists should know before beginning your treatment?*

*If so, please explain:* _____

## Client Waiver

*I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I also understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. I hereby release Skin Sense from any liability pertaining to treatments, understanding that results cannot be guaranteed due to individual skin type(s) and condition(s).*

*Client Signature:* _____ *Date:* _____