Facial Treatment Intake and Consent

Name: _____ Date: _____

Address: _____

Cell Phone: _____ Home/Office Phone: _____

Date Of Birth: _____ Age: _____ Do you smoke? _____ How often? _____

Email: _____

Have You Been Treated For: (Please Circle All That Apply):

Acne Depression Skin High Blood Pressure Cold sores Diabetes Cancer Epilepsy

Please List Any Allergies/Allergic:

_____

List Any Medications You Are Currently Taking:

_____

Are You Pregnant? ____ Trying To Get Pregnant? ____ Hormone Therapy? ____ Are You Prone To Cold Sores? ___

Circle Your Level Of Stress: 1 2 3 4 5 6 7 8 9 10

Circle Your Normal Level Of Stress: 1 2 3 4 5 6 7 8 9 10

How Many Ounces Of Water Do You Drink Daily? _____ Do You Take Supplements/Vitamins? _____

Do You Exercise? _____ If So, How Often:_____

Your Last Sunburn:_____ Do You Use Tanning Beds?_____

When You Go Into The Sun, Do You (Please Circle Only One):

Always Burn Usually Burn Sometimes Burn Rarely Burn Very Rarely Burn Never Burn

Have You Ever Been Under The Treatment Of A:

Dermatologist_____ Plastic Surgeon____ Esthetician____

If So, For What Skin Condition?_____

Are You Concerned About Skin Conditions On Your Body? (Circle All That Apply)

Sun Spots Skin Laxity Dry/Rough

What Skin Care Line Are You Currently Using?_____

Do You Use A Daily Sun Block?_____ If Not , Why?_____

Circle How You Feel About Your Overall Quality Of Your Skin:

(BAD) 1 2 3 4 5 6 7 8 9 10 (Fantastic)

Your Skin Type: (Please Circle Only One)

Normal Dry/Dehydrated Oily Acne/Acne Prone Rosacea

In Order Of Importance, Please Rank 1 (Most Important) to 5 (Least Important) Improvement In The Next 30 Days.

____ Reduction Of Fine Lines ____ Reduction Of Brown Spots/Sun Damage

____Reduction Of Oil/Acne ____Acne Scars ____Reduction Of Redness

Thank You For Completing This Confidential Questionnaire. This Information Will Allow Your Professional Skin Care Specialist To Provide The Optimum Products And Services.

Signature: _____ Date: _____

Parent Signature: _____Date:_____

Licensed Esthetician: _____ Date: _____

Treatment Plan (to be completed by Esthetician)