Skin Care Consultation Form

CLIENT INFORMATION

Sex:

◯ Male ◯ Female

Email: _____

EMERGENCY CONTACT

Full name: _____ Relationship: _____

Contact information:

INSURANCE INFORMATION (IF APPLICABLE)

Insurance carrier: _____ Insurance plan: _____

Policy number: _____ Contact number: _____

Group number: _____ Social security number: _____

SKIN CARE

Skin care goals:

Skin care challenges:

- ☐ Wrinkles/fine lines
- ☐ Acne/acne scarring
- ☐ Aging
- ☐ Sensitivity
- ☐ Hyperpigmentation/sun damage
- ☐ Redness/rosacea
- ☐ Melasma
- ☐ Other

Current skin condition diagnosis (if applicable):

Have you ever had a facial or skin treatment before?

◯ Yes ◯ No

If yes, what treatments have you had:

Skin care products you currently use:

- [ ] Cleanser/face wash
- [ ] Sunscreen
- [ ] Serums
- [ ] Face scrub/exfoliants
- [ ] Lip product(s)
- [ ] Toner
- [ ] Bar soap
- [ ] Eye product(s)
- [ ] Moisturizer
- [ ] Other

If yes, please state the brand:

Have you received hair removal services?

- ◯ Yes
- ◯ No

If yes, how long ago, and please describe:

Have you received chemical peels, lasers, or microdermabrasion treatments?

- ◯ Yes
- ◯ No

If yes, how long ago, and please describe:

Have you received Botox, Juvederm, or dermal fillers?

- ◯ Yes
- ◯ No

If yes, how long ago, and please describe:

Additional notes:

HEALTH

Please list any current medical diagnosis you have:

Please list any current medications (oral/topical) you are taking:

Please list any current allergies you have:

Tick the box if you're wearing any of the following:

- [ ] Contact lenses
- [ ] Pacemaker
- [ ] Body piercings
- [ ] Metal implants
- [ ] Other

Do you take any of the following supplements?

- [ ] Multivitamin
- [ ] Vitamin D/D3
- [ ] Zinc
- [ ] B Complex/B12
- [ ] Garlic
- [ ] Folic acid
- [ ] Other
- [ ] Vitamin C
- [ ] Melatonin
- [ ] Omega 3/fish oil
- [ ] Coenzyme Q10
- [ ] Calcium
- [ ] Biotin

Are you taking any birth control?

◯ Yes ◯ No

If yes, please specify:

Are you pregnant, trying to become pregnant, or just had a baby?

◯ Yes ◯ No

Are you menopausal and experiencing any issues?

◯ Yes ◯ No

If yes, please elaborate:

Are you undergoing hormone replacement therapy?

◯ Yes ◯ No

If yes, please elaborate:

Do you shave?

◯ Yes ◯ No

If yes, what is your current preferred method of shaving:

Are you experiencing any irritation from shaving?

◯ Yes ◯ No

Tick the boxes if you do any of the following:

- ☐ Smoke
- ☐ Drink alcoholic beverages
- ☐ Drink caffeinated beverages

If yes, please state how often:

ADDITIONAL INFORMATION

Specify below:

Client signature:

Date: _____ dd / mm / yyyy