client name _____ (first) _____ (last) therapist name _____

client address _____ apt/unit _____

city _____ zip code _____ telephone O home O work (____) _____

date of consultation _____ birthday _____ (month) _____ (day) O under 21 O 21-30 O 31-40 O 41-50 O over 50

how did you hear of us? _____

_____

client history

1. Are you currently, or within the last year, under a physician's care? .....O yes O no
2. Have you undergone any surgery in the last nine months? .....O yes O no
   If yes, specify _____
3. Have you had any of these health problems in the past or present?
   O cancer O hormone imbalance
   O diabetes O hysterectomy
   O epilepsy O thyroid
   O heart problem O varicose veins
   O cold sores
4. List any medications and vitamins that you take regularly.
   medications: _____
   vitamins: _____
5. Do you smoke? .....O yes O no
   Had chemical peels? .....O yes O no
   Use Retin-A? .....O yes O no
   Ever used the acne drug, Accutane? O yes O no
   Follow a restricted diet? .....O yes O no
   Exercise regularly? .....O yes O no
   Have regular sleep patterns? ....O yes O no
   Have your hair frosted, highlighted or chemically-lightened? .....O yes O no
   Wear contact lenses? .....O yes O no
   Have metal implants or pacemaker? .....O yes O no
6. What temperature of water do you use to cleanse with?
   O cool O warm O hot
7. Do you have any special skin problems pertaining to your face? .....O yes O no
   If yes, specify _____
   _____
8. Do you have any special concerns pertaining to your body? .....O yes O no
   If yes, specify _____
   _____
9. What types of skin care products are you currently using?
   O soap O toner O masque
   O cleanser O moisturizer O scrub/peel
   O other _____
10. Have you ever had a body spa treatment before? .....O yes O no
    If yes, which treatments?
    _____
    _____
    _____

female clients only

11. Are you taking oral contraception? O yes O no
12. Are you pregnant or trying to become pregnant? .....O yes O no
13. Are you lactating? .....O yes O no

male clients only

14. What is your current shaving system? O wet O electric
15. Do you ever experience irritation from shaving? .....O yes O no
16. Do you experience ingrown hair? O yes O no

oil secretion

1. Do you experience breakthrough oily shine during the day? .....O yes O no
2. Do you experience skin break-outs? O yes O no O occasionally

moisture hydration

1. How much plain water do you consume daily?
   _____
2. Do you take laxatives or diuretics? O yes O no O occasionally
3. How many alcoholic beverages do you consume weekly? .....O 1-3 O 4+
4. Do you ever experience these conditions on your skin?
   O Flakiness O Tightness O Obvious Dryness
5. If you sunbathe, do you use a sunscreen / sunblock on your skin? O yes ____ (spf) O no

capillary activity

1. Do you burn easily in moderate sunlight? O yes O no
2. Do you blush easily when nervous? O yes O no
3. Do you have a tendency to redness? O yes O no
4. Have you ever suffered any sinus problems? O yes O no

nerve activity

1. Do you drink caffeinated beverages (coffee, tea, soft drinks)? .....O yes O no
   How many daily? _____
2. Do you take any stimulants or slimming tablets? O yes O no O occasionally
3. What level do you consider your pain threshold to be?
   O low O medium O high
4. Have you ever experienced any claustrophobia? .....O yes O no
5. What type of massage pressure do you prefer? O light O firm
6. Have you ever had a reaction to any of the following?
   O cosmetics O pollen O animals
   O medicine O food O fragrance
   O iodine O AHAs O sunscreens
   O other _____

questions to update every visit

1. Are you currently having or due for your menstrual period? .....O yes O no
2. Have you had any recent dental x-rays? O yes O no
3. Have you started any new medication? O yes O no

   If yes, specify _____

To be completed by your skin care therapist: Contra-indications to any treatment:

1. _____
2. _____
3. _____

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.

client signature