



Confidential Skin Health Survey

PLEASE PRINT

Today's Date _____

First Name _____ Last Name _____ Date of Birth _____

Street _____ Apt# _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Dermatologist/Physician _____ Phone _____

Emergency Contact _____ Phone _____

Your Occupation _____ Phone _____

Referred by: Friend _____ Mailer _____ Walk-in _____ Gift Certificate _____ Other _____

Esthetician Name _____

1. Is this your first time? _____
2. What is the reason for your visit today?
3. What special areas of concern do you have?
4. Are you presently under a physician's care for any current skin condition or other problem?
If yes, what problem?
5. Are you pregnant?
6. Are you taking birth control pills? _____ If so, what type?
7. Hormone replacements?
8. Do you wear contact lenses?'
9. Do you smoke?
10. Do you often experience stress?
11. Have you had skin cancer?

12. Are you now using or used in the past: Azelex _____ Differin _____ Renova _____ Retin-A _____ Tazarae _____ Glycolic or alpha hydroxy acids _____ if so, when and for how long?

13. Are you now using, or have you ever used Accutane? _____ If so, when, and how long?

14. Do you have acne? _____
If so, how frequent?
15. Do you have any allergies to cosmetics, foods, or drugs?
Please list if any
16. Are presently taking medications.... oral or topical? _____ If so please
list _____
17. What products do you use presently? Soap _____ Cleansing milk _____
Toner _____ Scrub _____ Mask _____ Creams _____
Sunscreen _____ Other: List _____
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Please circle if you are affected by or have any of the following:

Asthma	Fever Blister	Hysterectomy	Sinus Problems
Cardiac Problems	Headaches- Chronic	Immune disorder	Skin Diseases-other
Depression or Anxiety	Hepatitis	Lupus	Urinary or Kidney problems
Eczema	Herpes	Metal bone, pins, or plates	
Epilepsy	High blood pressure	Pacemaker	

Please explain above problems or list any other significant _____
issues.

I understand that services offered are not a substitute for medical care and any information provided by the therapist is educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid therapist providing better service and is completely confidential.

SPA POLICIES

1. Professional consultation is required before initial dispensing of products.
2. Our active discount rate is only effective for clients visiting every 4 weeks.
3. We do not give cash refunds
4. We require a 24-hour cancellation notice

I fully understand agree to the above spa policies

Name: _____ Date _____

1. What areas of interest or concern do you have?

Please check all that apply.

- Facial fine lines/wrinkles
- Frown lines between brows
- Wrinkles/lines around nose/mouth
- Facial fullness/drooping
- Diet/Exercise resistant fat
- Unwanted hair
- Texture of skin/pore size
- Brown spots/age spots/freckle
- Uneven skin tone
- Double Chin
- Length/fullness of eyelashes
- Home skin care regime
- Stress incontinence
- Adult Acne

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

2. When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than, True Age, Older Than 1 2 3 4 5

3. When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles, moderate to deep lines or other cosmetic issues.

Not Concerned Somewhat Concerned Very Concerned 1 2 3 4 5

4. If you are a new client, how did you hear about us?

Radio ___ Referral (who may we thank) ___ Internet (google, Bing, etc.) Name: Facebook

Yelp ___ Magazine ___ Walk in ___ Other ___

Best way to contact: 1. e-mail address ___ 2. Cell Phone _____

* Are you interested in an educational party? (You and 5-15 friends, special pricing, appetizers, wine)

*Approval to use before and after photos for education or advertising _____

*Approval to send you information on products and services (including special offers) _____

- I am not interested in any additional services at this time

↓ For Staff Use Only ↓ Provider: Follow-up Date Completed by (name) θ Initial Inquiry/Information Given θ Contact in future – give date θ Products θ Free consultation θ Procedure scheduled θ Procedure completed Comments:
