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CLIENT CONSULTATION CARD

Your Health

1. Within the last year, have you been under a dermatologist's or other physician's care? ○YES○NO
   If yes, please specify
2. Have you had any health problems in the past or present? ○YES○NO
   If yes, please specify
3. List any medications, supplements, vitamins, diuretics, slimming pills, Isotretinoin, etc. That you take regularly: Medication List
4. Do you smoke? ○YES○NO
5. Do you exercise regularly? ○YES○NO
6. Do you follow a restricted diet? ○YES○NO
7. Do you wear contact lenses? ○YES○NO
8. Do you have metal implants, a pacemaker or body piercings? ○YES○NO
9. Rate your level of stress on a scale of 1 to 5 (1= Low stress, 5 = High stress) 1
10. Do you have any allergies? ○YES○NO
    If yes, please specify
11. Do you sunbathe or use tanning beds? ○YES○NO
12. Do you drink more than 4 caffeinated beverages daily (coffee, tea, soft drinks)? ○YES○NO
13. Have you ever experienced claustrophobia? ○YES○NO

Your Skin

14. What are your specific concerns/challenges with your skin? Skin concerns
15. What skin care products are you currently using? FACE: ☐ Soap☐ Cleanser☐ Toner☐ Moisturizer☐ Masque☐ Exfoliator☐ Eye Products
    BODY ☐ Soap☐ Shower Gel☐ Scrubs☐ Oil☐ Body Moisturizer☐ Depilatory Products ☐ Self Tanners
16. Have you ever had chemical peels, Microdermabrasion, or any resurfacing treatments? ○YES○NO
    In the last month? ○YES○NO

verified by approveme

17. Do you use Retin-A, Renova, Adapalene or any other prescription skin products? ○YES○NO
    In the last 3 months? ○YES○NO

18. Are you currently using any products that contain the following ingredients? ☐ Glycolic Acid☐ Lactic Acid☐ Any exfoliating Scrubs☐ Any Hydroxy Acid Product☐) vitamin a derivatives (i.e., Retinol)
19. Do you ever experience these conditions on your skin? ☐ Flakiness☐ Tightness☐ Obvious Dryness
20. What SPF sunscreen do you use on your face? Face SPF Body? Body SPF

21. Do you burn easily in moderate sunlight? ○YES○NO

22. Do you have a tendency to redness? ○YES○NO

23. Do you suffer from sinus problems? ○YES○NO

24. Do you ever experience burning, itching or stinging sensations on your skin? ○YES○NO

Female Clients Only

25. Are you currently taking contraception? ○YES○NO

26. Are you pregnant or trying to become pregnant? ○YES○NO

27. Are you lactating? ○YES○NO

28. Are you currently having or due for your menstrual period? ○YES○NO

Male Clients Only

29. Do you have any shaving challenges? ○YES○NO

Questions To discuss Every Visit

30. Have you started any new medication since your last visit? ○YES○NO

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. ○AGREE

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This consultation card is used to evaluate your individual skin care needs. We will maintain the confidentiality of this information, and will disclose this information only: (1) to our staff members, (2) to quality assurance and quality control personnel, (3) to our product supplier and manufacturer. We will not provide this information to anyone else, except as required by law, and we will not sell this information to anyone. We may, however, contact you with product-related information.

X _____

Signature Certificate

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