CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PLEASE PRINT **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 _____ **E-Mail:** _____

Referred by (Please Check One): ___Friend ___Mailer ___Walk-by ___E-mail ___Gift Certificate Other_____

Skin Care Professional Name: _____

1. **What is the reason for your visit today?** _____

2. **What special areas of concern do you have?** _____

EXPECTATIONS and HISTORY

3. **Which conditions would you like to improve? (Please Check all that apply)**

___ Acne Scarring ___ Age Spots ___ Fine Lines & Wrinkles ___ Broken Capillaries ___ Acne

___ Enlarged Pores ___Hyperpigmentation ___Stretch Marks ___ Surgical/facial scars ___ Other

4. **Have you ever had facial treatment in the past**? YES NO

5. **How would you describe your skin**? __ Normal __ Dry __ Oily __ Combination __ Sensitive __ Sun Damaged

6. **How would you rate your skin? (Please Circle One)**

1- Always burns, never tans **2 -**Always burns easily, tans slightly **3** -Burns moderately – tans gradually

4 - Rarely burns – Deep tan **5** -Seldom burn – Always tans well **6** - Never burns – Deeply pigmented

7. **Do you ever experience** ___Flakiness ___Tightness ___ Redness ___ Excessive oily shine during the day?

8. **What is your present skin regimen?** ___Soap & Water Only ___Cleanser ___Toner ___Masque ___Moisturizer

___Exfoliation ___SPF Daily Other_____

9. **Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin?** YES NO
If yes, what are they? _____

10. **Do you blush easily?** YES NO

If yes, what are the contributing factors?:

___Emotions ___Foods ___Temperature Changes Other _____

11. **Do you**: ___Sunbathe? ___Use a tanning bed? **How Often?** _____

12. **Have you ever had: ___**Peels ___Microdermabrasion ___Facial Surgery ___Cosmetic Surgery

___Botox ___Collagen Injections ___Laser Resurfacing **How Recently?**_____

13. **Are you under treatment for any current skin condition?** YES NO

If yes, please list: _____

14. **How does your skin heal: ___**Fast Scars Pigments? ___Scars? ___Pigments?

15. **Do you bruise easily?** YES NO

16. **Do you get sores/blisters (Herpes Zoster/Shingles)**? YES NO

17. **What medications/hormone replacement/vitamins do you presently take?**

_____

18. **Have you ever used**: ___Accutane ___Retin-A ___Renova ___Topical Antibiotics___ Differin ___Tazarac

___Hydroquinone ___Alpha Hydroxy Acids **When and for how long?** _____

19. **Any personal or family history of skin cancer?** YES NO

Provide detail _____

20. **How would you describe your overall health?** ___Excellent ___Good ___Fair ___Poor

21. **Have you ever had a reaction to:** ___Cosmetics ___Metals ___Medication ___Food ___Fragrance
___Airborne Particles __Other **Explain** _____

22. **Please Circle YES or NO**

For Women:

Oral Contraceptives? YES NO

Are you pregnant or trying to get pregnant? YES NO

Are you taking hormone replacement? YES NO

Do you experience hormone imbalances? YES NO

For Men:

Do you shave with __Electric Shaver? __Razor?

Do you experience skin breakouts? YES NO

Do you have ingrown hair? YES NO

23. **Have you had any of the following, past or present? (Circle all that apply to you)**

Acne	YES	NO	When?_____	Allergies	YES NO
Blood Pressure	HIGH	LOW	NORMAL	Cancer	YES NO
Cataracts	YES	NO		Claustrophobic	YES NO
Diabetes	YES	NO		Eczema	YES NO
Epilepsy	YES	NO		Hay Fever	YES NO
Heart Disease/Conditions	YES	NO		Hepatitis	YES NO
List:_____				HIV/AIDS	YES NO
Infections	YES	NO		Lupus	YES NO
Menopausal	YES	NO		Metal Implants	YES NO
Pace Maker	YES	NO		Phlebitis	YES NO
Serious Injury	YES	NO		Thyroid	HIGH LOW NORMAL

List:_____

Do you wear contact lenses? YES NO

Your esthetician will recommend the appropriate schedule for future facial treatments or physician referral in order to achieve your skin improvement goals.

INFORMED CONSENT RELEASE

I _____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the skin care professional will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependent upon my age, skin condition, and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will inform my skin care professional immediately.

I release and hold harmless the skin care professional_____, Retreat Spa and Salon, and the staff harmless from any liability for adverse reactions that may result from this treatment.

POLICIES

1. We require 24-hours notice for cancellations. Cancellation for Monday must be phoned in on the Friday before.

2. If you are not satisfied with your service or products, please contact your skin care professional within 24 hours after your appointment so that the situation may be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all of the foregoing information

_____ _____

(Client Signature) (Date)