New Client Questionnaire

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Today's Date: ______________________________________

Name: ____

First Middle Last

Address: ____

____

City State Zip

Home Phone: ____Cell Phone: _________________________

Email: ____

Birthday: ______________________________________Age (Optional): _________________________Gender: Male__Female__

Do you have children? Yes No

Are you married? Yes No

What is your anniversary date? ____

What is your occupation? ____

Requested Employee: ____

How did you hear about us?

[ ] Internet Search	[ ] Magazine	[ ] Radio
[ ] Mailing/Postcard	[ ] Office	[ ] Friends/Family

Why did you leave your previous salon/spa? ____

____

What are the cosmetic improvements you would like to see in your skin?

____

____

Are you pregnant or lactating? Yes No

If Yes, you may need to consult your obstetrician.

Do your wear contact lenses? Yes No

Remove contacts if eyes are sensitive, or if having microdermabrasion.

Do you have permanent makeup? Yes No (If YES, Where?___________________________________)

Do you currently have a sunburn/windburn/red face? Yes No Why? _____________________________

Do you go to tanning booths? Yes No When was the last date you used the tanning bed?____________________

Do you currently use or receive depilatories or waxing? Yes No How many weeks since your last waxing, etc?_______________

Are you applying any topical medications at this time? Yes No

(If YES, Which ones? _________________________) High % of certain ingredients may increase sensitivity

Are you currently using any topical Retanoid prescriptions (Retin-A/Renova/Differin/Tazorac/Avage?)

Yes No What strength? _________________________For how long?__________

(Discontinue use five days before and after treatment)

Are you currently using Accutane? Yes No How long?_____________

Have you had a chemical peel or any type of procedure with a medical device? Yes No

Within the last 14 days? Yes No

Do you have regular collagen, Botox or any other dermal filler injections? Yes No

Have you recently had facial surgery? Yes No Describe:____

How long ago? ____

Had you recently had laser resurfacing? Yes No When:______________________

What type of work do you do? ____

Regular airtime travel? Yes No How Often? ________________________

Do you participate in vigorous aerobic activity or sports? Yes No What type? ___________________

Do you smoke or use tobacco? Yes No

Do you develop cold sores or blisters? Yes No Last Breakout? ________________

Are you allergic or sensitive to? (circle all that apply) Milk Apples Citrus Grapes

Aloe Vera Asprin Perfumes Latex hyrdoquinoe mushrooms Other: _______________________

Are you sensitive to alcohol based products? Yes No

Have you ever used any other products that caused a bad reaction? Yes No What? _____

Are you taking any medications at this time? ____

(Antibiotics may increase sensitivity).

What is your hereditary background? ____

Natural eye color: Blue Green Hazel Gray Lt. Brown Med. Brown Dark Brown

Natural hair color: Blonde Red Lt. Brown Med. Brown Dk. Brown Black White Gray/Silver

Skin Tone: Pale/White Light Medium Reddish Freckled Sallow Lt. Olive Med. Olive Dark Olive

Lt. Brown Dark Brown Soft Black Black

Do you consider your skin: Sensitive Resilient Unsure

Describe your skin (Circle all that apply):

Thick	Thin	Saggy	Firm	Normal	Dry
Oily	Acne	Blackheads	Milia	Cysts	Breakouts
Acne-Scarred	Large Pores	Small Pores	Florid	Rosacea	Eczema
Freckled	Sun-Damaged	Uneven/Blotchy	Mature	Wrinkled	Patchy dryness
Sallow	Melasma	Perfume-Stained	Hypo-pigmentation	Psoriasis	Hyper-Pigmentation
Dehydrated	Asphyxiated	Telangiectasia/broken surface capillaries			

What is your daily skin care regimen?

____

____

Treatment Recommendations:____

Patch Test: ______Date:________________Solution:_____________________TestArea:_____________Result_____________

Patient Signature: ____