



Facial Client Information

NAME: _____ DATE: _____

IS THIS YOUR FIRST FACIAL? YES NO

PLEASE LIST ANY ALLERGIES OR SENSITIVITIES:

HAVE YOU EVER HAD A REACTION TO ANY OF THESE? (CIRCLE ALL THAT APPLY.)

- | | | | |
|-----------|-----------|---------------|------------|
| COSMETICS | MEDICINES | IODINE | FRAGRANCES |
| POLLEN | FOOD | HYDROXY ACIDS | SUNSCREENS |

DO YOU HAVE ANY MAJOR HEALTH PROBLEMS? PLEASE SPECIFY BELOW.

PLEASE CIRCLE ANY OF THE FOLLOWING SKIN CARE PRODUCTS YOU ARE USING AT HOME:

Face

Body

- | | | | |
|----------|----------------------|-------------|--------------|
| CLEANSER | MOISTURIZERS | BAR SOAP | MOISTURIZERS |
| MASQUES | SUNSCREEN | SHOWER GEL | SUNSCREEN |
| SERUMS | EXFOLIANTS | OILS | EXFOLIANTS |
| TONER | CORRECTIVE TREATMENT | SELF-TANNER | DEPILATORIES |

LIST ANY RX SKIN PRODUCTS YOU ARE USING:

HAVE YOU EVER USED ACCUTANE? YES NO

PLEASE LIST ANY OTHER MEDICATIONS, VITAMINS, OR SUPPLEMENTS YOU TAKE REGULARLY.

CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | | | |
|----------------|-------------------|-------------|-------------------------|
| CHEMICAL PEELS | MICRODERMABRAISON | RESURFACING | FACIAL COSMETIC SURGERY |
|----------------|-------------------|-------------|-------------------------|

MY SKIN IS...

- FAIR (ALWAYS BURNS, NEVER TANS)
- MEDIUM-FAIR (USUALLY BURNS, DIFFIULTY TANNING)
- MEDIUM (TANS ABOUT AVERAGE)
- MEDIUM-DARK (TANS EASILY, BURNS SOMETIMES)
- DARK (BROWN SKIN, ONLY TANS)
- VERY DARK (BLACK SKIN, NEVER BURNS)
- OILY
- DRY
- COMBINATION
- DEHYDRATED
- PRONE TO REDNESS

DO YOU EVER EXPERIENCE SKIN BREAKOUTS? IF SO, WHAT TYPE?

STRESS-RELATED HORMONAL DIET-RELATED

DO YOU EVER EXPERIENCE THESE CONDITIONS?

FLAKINESS TIGHTNESS ITCHING BURNING

WHAT IS YOUR PAIN THRESHOLD? LOW MEDIUM HIGH

ARE YOU CLAUSTROPHOBIC? YES NO

HOW MUCH WATER DO YOU CONSUME DAILY? _____

HOW MANY CAFFEINATED DRINKS DAILY? _____

DO YOU SUNBATHE OR USE TANNING BEDS? YES NO

WHAT SPF SUNSCREEN DO YOU USE ON YOUR FACE? _____ BODY? _____

DO YOU SMOKE? YES NO

DO YOU EXERCISE REGULARLY? YES NO

DO YOU WEAR CONTACT LENSES? YES NO

DO YOU HAVE METAL IMPLANTS, A PACEMAKER, OR BODY PIERCINGS? YES NO

RATE YOUR STRESS LEVEL ON A 1-5 SCALE (1=LOW, 5=HIGH) _____

Female Clients Only:

DO YOU TAKE BIRTH CONTROL PILLS OR HAVE AN IUD? YES NO

ARE YOU CURRENTLY PREGNANT OR LACTATING? YES NO

Male Clients Only:

WHAT IS YOUR SHAVING SYSTEM? ELECTRIC WET SHAVE

DOES SHAVING IRRITATE YOUR SKIN? YES NO

DO YOU GET INGROWN HAIRS? YES NO