



CONFIDENTIAL CLIENT INFORMATION

Please read and complete this entire form. We use this information to communicate with you and to help tailor your Skin Sense experience to your particular circumstances. We keep all client information confidential and use the information only as described in this form.

Name _____ E-mail _____

Address _____ Home Phone _____

City _____ Work Phone _____

State _____ Zip Code _____ Mobile Phone _____

Date of Birth ____/____/____ Occupation _____

How did you learn about Skin Sense? _____

	Yes	No		
Have you ever been to a spa before?	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, what kind and where? _____				
Have you seen a Dermatologist the past five years?	<input type="checkbox"/>	<input type="checkbox"/>		
If so are you under his/her care now?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you had cosmetic/plastic surgery?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever or are you currently using Retin A or Renova?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever or are you currently using Glycolic Acid or AHA?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had a peel or dermabrasion?	<input type="checkbox"/>	<input type="checkbox"/>		
Any major illnesses or operations?	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, explain. _____				
Do you have any areas of discomfort?	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, explain. _____				
Are you currently taking any medications, vitamins, or supplements?	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, please list. _____				
Are you taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you in any stage of or having any symptoms of menopause?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, explain. _____				
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>		
Do you exercise?	<input type="checkbox"/>	<input type="checkbox"/>		
Are you dieting or fasting now?	<input type="checkbox"/>	<input type="checkbox"/>		
Have you ever had any nail fungus?	<input type="checkbox"/>	<input type="checkbox"/>		
How much water do you drink daily?	<input type="checkbox"/> None	<input type="checkbox"/> 1-2 cups	<input type="checkbox"/> 3-5 cups	<input type="checkbox"/> 6+ cups
How do you rate your stress level?	<input type="checkbox"/> Low	<input type="checkbox"/> Moderate	<input type="checkbox"/> High	

(Please complete the remainder of this form on the reverse side.)

Have you ever experienced any of the following? (Please check all that apply and indicate the year)

- | | | | |
|------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Chronic Neck / Back Pain | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> PMS | <input type="checkbox"/> Infectious Disease (explain below) | |

Please describe any other health conditions that you have: _____

Please provide any other information of which you would like us to be aware: _____

We appreciate your understanding that Skin Sense may use the information in this form to provide services and products to you. We know you will understand the importance of letting us know if any of the information you provide to us in this form or otherwise changes in any way. We will rely on you to inform us of those changes when they occur. We appreciate also your agreement by signing below that Skin Sense cannot be liable for the outcome or effects of its services and products beyond the amount paid for them.

Skin Sense should not contact me by e-mail

Client Signature

Date