



# Client Information Form

Thank you for choosing to trust Skin Sense with your skin. Please answer the following questions so that our Estheticians may have a better understanding of your general health and lifestyle, enabling us to accurately analyze and access your unique skin care needs.

## Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Health History

What type of work do you do? \_\_\_\_\_

Have you seen a Dermatologist in the past year? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list Dermatologist's name, contact information and reason for visit: \_\_\_\_\_

Are you currently taking any medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please list: \_\_\_\_\_

What is your genetic background? (This is for skincare analysis only) \_\_\_\_\_

How is your general health? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Please circle the following conditions you have/had experienced:

- |                |                         |                 |                   |                 |           |                |          |
|----------------|-------------------------|-----------------|-------------------|-----------------|-----------|----------------|----------|
| hypertension   | cold sores              | anemia          | cancer            | seizures        | headaches | fainting       | contacts |
| metal plate    | hernia                  | lupus           | thyroid disorders | eating disorder | asthma    | claustrophobia | epilepsy |
| diabetes       | stroke                  | irregular pulse | high cholesterol  | hear attack     | hepatitis | varicose veins |          |
| tooth fillings | high/low blood pressure |                 |                   |                 |           |                |          |

Do you take nutritional supplements? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a tendency to scar? Yes \_\_\_\_\_ No \_\_\_\_\_

### Allergies:

Have you ever had an allergic reaction to any of the following:

Aspirin or Salicylates Yes \_\_\_\_\_ No \_\_\_\_\_

Milk Yes \_\_\_\_\_ No \_\_\_\_\_

Apples Yes \_\_\_\_\_ No \_\_\_\_\_

Citrus Yes \_\_\_\_\_ No \_\_\_\_\_

Grapes Yes \_\_\_\_\_ No \_\_\_\_\_

Ingredients in skincare products Yes \_\_\_\_\_ No \_\_\_\_\_

Fish, marine or iodine allergies Yes \_\_\_\_\_ No \_\_\_\_\_

Latex Yes \_\_\_\_\_ No \_\_\_\_\_

If checked yes to any of the above, please explain \_\_\_\_\_

Please list any other known allergies \_\_\_\_\_  
 Have you ever had Herpes Simplex? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclovir) or Abreva? \_\_\_\_\_  
 Are you being treated for Hepatitis? Yes \_\_\_\_\_ No \_\_\_\_\_

Female clients only:

Are you on hormone replacement therapy? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Are you presently taking birth control pills? Yes \_\_\_\_\_ No \_\_\_\_\_

## Skincare History

Are you currently having skin treatments? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what type of treatment(s)? \_\_\_\_\_

Please circle if you are presently experiencing or have experienced in the past:

Skin Cancer Broken Capillaries Dermatitis Treatment Reactions Keloid Scarring Hypopigmentation  
 Acne Hyperpigmentation Rosacea

Please circle if you have or have you had any of the following in the last 14 days:

Facial Cosmetic Surgery Chemical Exfoliation (Peels) Botox Injections Extractions Collagen Injections  
 Permanent Cosmetics Fillers Light Treatments Waxing Laser Hair Removal  
 Laser Resurfacing Microdermabrasion Hair Treatments (perm, color, etc.)  
 Other \_\_\_\_\_

### Home Care:

Please circle the skincare products are you currently using at home:

Cleanser Vitamin C Toner Exfoliants/Scrubs Moisturizer Specialty Products SPF Mask

Please circle if you are using or have used any of the following:

Benzoyl Peroxide (BP) Glycolic Acid (AHA) Lactic Acid (AHA) Resorcinol Salicylic Acid (BHA)  
 Sulfur Vitamin C Vitamin A Hydrocortisone (HC) Hydroquinone (HQ)

Please circle if you have been prescribed the following products:

Tretinoin (Retin A, Retin-A Micro®, Renova, Avita) Adapalene (Differin®) Azelaic Acid (Azelex®, Finacea™)  
 Tazarotene (Tazorac®) Isotretinoin (Accutane) Triluma  
 Metrogel Other \_\_\_\_\_

### Sun Protection:

Do you use a sunscreen? Yes \_\_\_\_\_ No \_\_\_\_\_

What level of protection? \_\_\_\_\_

Do you sunbathe or participate in outdoor activities? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you tan in a tanning booth? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you tanned in a tanning booth in the last 14 days? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you had any direct sun exposure in the last 10 days? Yes \_\_\_\_\_ No \_\_\_\_\_

When exposed to the sun do you (Please circle one)

Always burn, never tan Always burn, sometimes tan Sometimes burn, sometimes tan Always tan

Do you feel your skin is sensitive? Yes \_\_\_\_\_ No \_\_\_\_\_

What skin conditions do you want to improve? (Please circle all that apply)

Acne and/or breakouts Rosacea Facial Scarring Uneven Tone Hyperpigmentation (freckles, age spots)  
 Enlarged Pores Dehydration Uneven Texture Oily Hypopigmentation  
 Fine Lines and Wrinkles Sun Damage Other \_\_\_\_\_

Is there any other necessary information your skincare specialists should know before beginning your treatment?

If so, please explain: \_\_\_\_\_

## Client Waiver

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I also understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. I hereby release Skin Sense from any liability pertaining to treatments, understanding that results cannot be guaranteed due to individual skin type(s) and condition(s).

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_