



# Client Skin Profile

*This information is completely confidential and to be used only for this analysis.*

Client Name \_\_\_\_\_ Spouse \_\_\_\_\_

Address \_\_\_\_\_

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

Telephone: Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_

Occupation \_\_\_\_\_ Children (ages) \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_

1) How are you caring for you skin?

Soap \_\_\_\_ AM \_\_\_\_ PM Brand \_\_\_\_\_ Moisturizer \_\_\_\_ AM \_\_\_\_ PM Brand \_\_\_\_\_

Cleanser \_\_\_\_ cream \_\_\_\_ lotion Brand \_\_\_\_\_ Masque \_\_\_\_ clay \_\_\_\_ non-setting Brand \_\_\_\_\_

Toner \_\_\_\_ AM \_\_\_\_ PM Brand \_\_\_\_\_ Scrub \_\_\_\_ daily \_\_\_\_ weekly Brand \_\_\_\_\_

Sunscreen \_\_\_\_ daily \_\_\_\_ occasionally Brand \_\_\_\_\_ Alpha hydroxy acid \_\_\_\_ Brand \_\_\_\_\_

2) Have you ever had a professional facial before? If yes, were you pleased with the result? \_\_\_\_\_

Date of your last skin treatment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3) Are you currently, or within the last year, under a physicians care? • Yes • No

4) Have you undergone any surgery in the last 9 months? If yes, please explain briefly. \_\_\_\_\_

5) Please define any health problems (past or present):

\_\_\_\_ Asthma                      \_\_\_\_ Heart Problems                      \_\_\_\_ Hysterectomy

\_\_\_\_ Diabetes                      \_\_\_\_ High Blood Pressure                      \_\_\_\_ Pacemaker

\_\_\_\_ Epilepsy                      \_\_\_\_ Hormone Imbalance                      \_\_\_\_ Other \_\_\_\_\_

6) Do you have any metal pins, devices, etc. in your body? \_\_\_\_\_

7) Are you using Retin-A? \_\_\_\_ Have you ever been on Accutane? \_\_\_\_ If so, when? \_\_\_\_\_

Have you had Botox injections? \_\_\_\_\_ Collagen Injections? \_\_\_\_\_

8) Please list all medications and vitamins that you are taking regularly \_\_\_\_\_

9) Do you have any special skin problems? \_\_\_\_ If yes, please explain briefly \_\_\_\_\_

10) Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_

11) How much water do you consume daily? \_\_\_\_\_

12) Have you ever experienced any claustrophobia? • Yes • No

13) Have you ever experienced sinus or allergy problems? \_\_\_\_ Sometimes \_\_\_\_ Never

14) Do you prefer a massage to be firm or light in pressure? \_\_\_\_\_

15) Do you take any, \_\_\_\_ sedatives                      \_\_\_\_ pain killers                      \_\_\_\_ sleeping pills                      \_\_\_\_ diuretics

16) Do you have any known allergies?                      \_\_\_\_ cosmetics                      \_\_\_\_ pollens                      \_\_\_\_ foods                      \_\_\_\_ animals

Referred by: Friend \_\_\_\_\_ Advertisement: \_\_\_\_ newspaper \_\_\_\_ yellow pages \_\_\_\_ magazine

*Thank you for your cooperation and enjoy your salon treatment!*

Signature \_\_\_\_\_ Date \_\_\_\_\_