

client name _____
last first

client address _____ apt/unit _____

city _____ state _____ zip _____

e-mail address _____ @ _____

telephone: home () _____ work () _____

age under 21 21-30 31- 40 41- 50 51- 60 60+

your health

- 1 Within the last year, have you been under a dermatologist or other physician's care? yes no
- 2 Within the last nine months, have you undergone any surgery? yes no
If yes, please specify _____
- 3 Have you had any health problems in the past or present? yes no
If yes, please specify _____
- 4 List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly.

- 5 Do you smoke? yes no
- 6 Do you exercise regularly? yes no
- 7 Do you follow a restricted diet? yes no
- 8 Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) _____

your skin

- 9 Do you have any special skin problems pertaining to your face or body? yes no
If yes, please specify _____
- 10 What skin care products are you currently using?
face: soap cleanser toner moisturiser masque exfoliator eye products
body: soap shower gel scrubs oil body moisturiser depilatory products self tanners

exfoliation history

- 11 Have you ever had chemical peels, laser, microdermabrasion or any resurfacing treatments? yes no
in the last month? yes no
- 12 Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? yes no
in the last 3 months? yes no
- 13 Are you currently using any products that contain the following ingredients?
 glycolic acid lactic acid any exfoliating scrubs
 any hydroxy acid product vitamin A derivatives (i.e. retinol)

moisture hydration

- 14 How much plain water do you consume daily? _____
- 15 How many alcoholic beverages do you consume weekly? _____
- 16 Do you ever experience these conditions on your skin? flakiness tightness obvious dryness
- 17 What spf sunscreen do you use on your face? _____ body? _____
- 18 Do you sunbathe or use tanning beds? yes no

capillary activity

- 19 Do you burn easily in moderate sunlight? yes no
- 20 Do you blush easily when nervous? yes no
- 21 Do you have a tendency to redness? yes no
- 22 Do you suffer from sinus problems? yes no

oil secretion

- 23 Do you ever experience oily shine during the day? yes no occasionally
- 24 Do you ever experience skin breakouts? yes no occasionally

nerve activity

- 25 Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) yes no
- 26 Do you ever experience a burning, itching sensation on your skin? yes no
- 27 Have you ever had a reaction to any of the following?
 cosmetics medicine iodine pollen food hydroxy acids animals
 fragrance sunscreens other _____

female clients only

- 28 Are you taking oral contraception? yes no
- 29 Are you pregnant and seeing changes in your skin? yes no
- 30 If yes, what changes are you experiencing? _____

male clients only

- 31 What is your current shaving system? electric wet shave
- 32 Do you experience irritation from shaving? yes no
- 33 Do you experience ingrown hairs? yes no

34 What are your skin care goals? _____

