Skin Care Client # ____________

CLIENT PROFILE

Date ____________ Birthday ________ / ________
month day

Name ____________ Phone (____)__________wk

Address ____________ Phone (____)__________hm

City ____________ State ________ Zip ________

Cell # ____________ E-mail ____________

Occupation ____________ Employer ____________

Preferred appt. day ____________ Time ____________

Allergies ____________

Age: ☐ Under 21 ☐ 21 - 30 ☐ 31 - 40 ☐ 41 - 50 ☐ Over 50

Referred by ____________

Skin Type (check all that apply): ☐ Dry ☐ Oily ☐ Combination

Skin conditions (check all that apply): ☐ Sunburn easily ☐ Blush easily
☐ Redness ☐ Acne ☐ Breakouts ☐ Flaking ☐ Tightness

Personal skin care products used (check all that apply): ☐ Cleanser ☐ Toner
☐ Moisturizer ☐ Soap ☐ Masque ☐ Scrub
Massage preference? ☐ Light ☐ Firm Do you use Retin-A? ☐ Yes ☐ No

Lifestyle: Work daily ☐ Yes ☐ No Daily water consumption? ________ oz.
Alcohol ☐ Yes ☐ No Soft Drinks? ________oz. Coffee? ________ cups
Regular sleep pattern? ☐ Yes ☐ No

Medical History:
Are you currently or within the last year under a physician's care? ☐ Yes ☐ No
Health Conditions: ☐ Allergies ☐ Thyroid ☐ Diabetes ☐ Hysterectomy
☐ Hormone imbalance ☐ Cancer

Other/Explain ____________

Current medications ____________

Check all that apply: ☐ Exercise ☐ Smoke ☐ Recent Surgery ☐ X-Rays

Female clients only: Are you in or due for your menstrual period? ☐ Yes ☐ No
Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Do you use oral contraception? ☐ Yes ☐ No

Male clients only: Skin breakouts? ☐ Yes ☐ No
Shaving system? ☐ Wet ☐ Dry Ingrown hairs? ☐ Yes ☐ No

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