

CLIENT INFO

Name _____ Date _____

Address _____

Phone _____

Email _____

PERSONAL INFORMATION

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you have any health problems or concerns that we need to be aware of before we begin this treatment? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 2. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Any recent surgery on your face, neck and shoulders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you taken Accutane® within the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you used Retin-A®/Renova®, or any powerful alpha hydroxy acids within the past 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a medical peel within the past 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a pacemaker or any pins in bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you currently wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you currently under a physician's care for any skin condition? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 11. Have you ever had an adverse reaction to a cosmetic product or ingredient? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 12. Have you ever had an adverse reaction to a skin care treatment? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 13. What are your skin concerns and challenges? | | |
| <hr/> | | |
| 14. What are you currently using on your skin? | | |
| Daytime _____ Evening _____ | | |
| Weekly / Special Treatments _____ | | |
| 15. My esthetician may choose to use surface peeling products during my facial and I give consent. | | |
| Client Signature _____ Date _____ Esthetician's Initials _____ Date _____ | | |

SKINREADING REVIEW

2nd visit: _____ Date _____

3rd visit: _____ Date _____

4th visit: _____ Date _____