



## CLIENT INFORMATION

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

E-Mail: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_

1. Do you have any health problems or concerns that we need to be aware of before treatment?

If the answer is yes, please describe. \_\_\_\_\_

2. Are you pregnant? \_\_\_ Yes \_\_\_ No

3. Any recent surgery on your face, neck, and shoulders? \_\_\_Yes \_\_\_No

4. Are you currently, or have you taken Accutane with the past 12 months? \_\_\_Yes \_\_\_No

5. Are you currently, or have you used Retin-A/Renova, or any powerful alpha hydroxy acids within the past 3 months? \_\_\_Yes \_\_\_No

6. Have you had a chemical peel within the past 6 months? \_\_\_Yes \_\_\_No

7. Do you have a pacemaker or any pins in bones? \_\_\_Yes \_\_\_No

8. Do you currently wear contact lenses? Yes \_\_\_ No \_\_\_

9. Are you currently under a physician's care for any skin condition? If yes, please describe.

\_\_\_\_\_

10. Have you ever had an adverse reaction to a cosmetic product or ingredient? If yes, please describe.

\_\_\_\_\_

11. Have you ever had an adverse reaction to a skin care treatment? If yes, please explain.

\_\_\_\_\_

12. What are your skin concerns and challenges?

\_\_\_\_\_

13. What products are you currently using on your skin?

Daytime \_\_\_\_\_ Evening \_\_\_\_\_

Weekly / Special Treatments \_\_\_\_\_

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date