SKINOLOGY CLIENT CONSULTATION

Name:______________________________ Date:_______________________________
Address:____ Apt:___________________
City: ______________________________ State:_____ Zip:___________________
Cell Phone:_________________________ Date of Birth:________________________
Home Phone:________________________ Work Phone:_________________________
E-Mail:____________________________ May we email you specials? Yes No
Profession:_________________________ Referred By:__________________________

HEALTH HISTORY

How many hours of sleep do you typically get? <6 6-7 7-8 8+ hrs
How often do you exercise? Daily 3-5x/wk 1-3x/wk Seldom Never
How many 8 oz glasses of water do you consume daily? None 1-2 3-5 6-7 8+
How many 8 oz glasses of caffeine do you consume daily? None 1-2 3-5 6-7 8+
How often do you drink alcohol? Daily 3-5x/wk 1-3x/wk Seldom Never
Do you wear contact lenses? Yes No **Do you smoke?** Yes No
What is your stress level? Low Medium High Excessive/Abnormal

None	Anxiety	Ulcers	Nervous Tension	Low or High Blood Pressure		
Overweight	Low Energy	Constipation	Lack of Exercise	Improper Diet	Colds	Sinus
Asthma	Diabetes	Arthritis	Bursitis	Rheumatism	Pacemaker	
Varicose Veins	Herpes	Hepatitis	Hypoglycemia	HIV	Cancer/Chemo	
Epilepsy	Botox/Fillers	Implants	Laser	Plastic Surgery	Silicone/Zyderm Injections	
Problems with:	Heart	Thyroid	Liver/Kidney	Blood Clotting	Muscle/Bone/Joint	

Are you taking any oral or topical medication, including herbs or vitamins?____________________________
Do you have any skin problems?____
Do you ache or have pain anywhere?____
Do you have any physical limitations?____
Have you had surgery within the last six months?____
Do you have any allergies?____
Are you pregnant or lactating? Yes No Is there anything else we should know?_________________

PLEASE COMPLETE FOR FACIAL/WAXING CLIENTS

Skin Type:	Normal	Dry Oily	Combination	Sensitive	
Sun Exposure:	Burn Easily	Tan Easily	Never Burn	Never Tan	Tanning Booth
Concerns:	Very Sensitive	Dehydrated	Wrinkles	Loss of Elasticity	Mature
Enlarged Pores	Acne/Cysts	Whiteheads	Blackheads	Acne Scars	Accutane
Redness	Rosacea	Eczema	Psoriasis	Mycosis/Fungal	Contact Dermatitis
Skin Cancer	Dilated Capillaries		Ingrown Hairs	Hyperpigmentation	
Eyes:	Wrinkles	Crows Feet	Puffiness	Dark Circles	Dark Shadows

Cleanser:	Exfoliation:
Toner:	Benzoyl Peroxide:
Moisturizer:	Alpha/Beta Hydroxy Acids:
Sunscreen:	Retinoid/Retin A:
Make-Up:	Other: