Name:_____ Referred by_____ Date:_____
Address:_____ DOB:_____ Age:_____
City:_____ Email:_____
State, Zip:_____ Occupation:_____
Cell Phone:_____ Home Phone:_____

Ethnicity: Latino [ ] Caucasian [ ] African American [ ] Asian [ ] Other [ ] _____
Check the areas you would like to improve with your skin:
Color [ ] Texture [ ] Freckles [ ] Wrinkles [ ] Eye Area [ ] Firmness [ ] Capillaries [ ] Plumpness [ ] Smoothness [ ]
Neck Area [ ] Decolletage [ ] Blackheads [ ] Acne [ ] Breakouts [ ] Premature Aging [ ] Dryness [ ] Pore Size [ ]
Congestion [ ] Scarring [ ] Other _____
List skin care you are currently using:_____
_____
Are you currently using: Retin-A [ ] Retinol [ ] AHA [ ] other peeling agent_____
If so: how long_____ Strength_____ Results_____
Have they achieved the results you want? Yes [ ] No [ ]
Do you use sunscreen daily? Yes [ ] No [ ]

Medical history:
Do you smoke? Yes [ ] No [ ] Consume Alcohol Yes [ ] No [ ] how often _____
How often do you have a bowel movement? Daily [ ] Less often then daily [ ]
How many hours of sleep do you get nightly?_____Are you pregnant [ ] breast feeding [ ]
Have you in the past or present or had any of the following problems? Epilepsy [ ] Diabetes [ ] Thyroid [ ] Heart Problems [ ] Cancer [ ] Hysterectomy [ ] Hormonal Imbalance [ ] Depression [ ] High or Low Blood Pressure [ ]
Other Medical Conditions: _____
Have you been under a physician's care during the past 3 years? No [ ] Yes [ ] If so, for what?
_____
Have you had plastic surgery? Yes [ ] No [ ] Date:_____ Surgeon _____
_____
Have you had a skin peel in the past 2 years? Yes [ ] No [ ] Results_____
Are you seeing a dermatologist? Yes [ ] No [ ] Are you currently taking Accutane or Roaccutane? Yes [ ] No [ ]
Using other medication? Yes [ ] No [ ] _____Taking or taken antibiotics past 6 months Yes [ ] No [ ]
Have you had skin cancer? Yes [ ] No [ ] _____
Have you ever experienced a sunburn that blistered? Yes [ ] No [ ] _____

Any known allergies to: cinnamon, egg, cosmetics, food, medication, animals, pollens, metals, sulphur or other?
_____
Do you usually experience allergic reactions to skin care or cosmetics? Yes [ ] No [ ]
Describe your allergic reactivity_____
Do you have a tendency to keloid scar or hyperpigment? Yes [ ] No [ ]
Are you currently taking medication? Yes [ ] No [ ] How Long _____ Name _____
Dietary or Herbal Supplements Yes [ ] No [ ] How Long _____ Name _____
Pre or probiotics Yes [ ] No [ ] How Long _____ Name _____
Vitamins **[ ]** Yes[ ] No [ ] How Long _____ Name _____
How much water do you drink daily? # glasses _____ Sugar intake?_____
How many servings of vegetables daily_____

Client Signature_____.Date_____
If under 18 parent signature is required_____Date_____

Date _____

Date_____

Home Care Purchased _____