SKINCARE QUESTIONNAIRE

NAME: ______________________________ DATE: ______________

ADDRESS: ____

PHONE NUMBER: ________________ EMAIL ADDRESS: ________________

BIRTH DATE: ____

TELL US ABOUT YOUR SKIN

WHAT IS YOUR SKIN TYPE? ☐ OILY ☐ COMBINATION ☐ DRY ☐ OTHER

WHAT ARE YOUR SKIN CONCERNS? CHECK ALL THAT APPLY

☐ FIRM SKIN: ANTI-AGING ☐ SMOOTH SKIN: TEXTURE ☐ CALM SKIN: SENSITIVITY

☐ BRIGHT SKIN: HYPERPIGMENTATION ☐ CLEAR SKIN: ACNE & BREAKOUTS

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

☐ ROSACEA ☐ BROKEN CAPILLARIES ☐ DERMATITIS ☐ KELOID SCARRING

☐ HYPOPIGMENTATION ☐ HYPERPIGMENTATION ☐ SKIN CANCER

DO YOU CONSIDER YOUR SKIN SENSITIVE (INCLUDING: REDNESS, STINGING, ITCHING, DRYNESS)? ☐ YES ☐ NO

IF YES, WHERE: ☐ FACE ☐ BODY ☐ BOTH

WHEN EXPOSED TO THE SUN DO YOU:

☐ ALWAYS BURN ☐ ALWAYS BURN, SOMETIMES TAN

☐ SOMETIMES BURN, SOMETIMES TAN ☐ ALWAYS TAN

HOMECARE

WHAT SKINCARE PRODUCTS ARE YOU CURRENTLY USING AT HOME?

☐ PRECLEANSE/MAKEUP REMOVER ☐ CLEANSER ☐ TONER ☐ SERUM

☐ EXFOLIANT/SCRUB ☐ MASK ☐ VITAMIN C ☐ MOISTURIZER ☐ SPF

WHAT PRODUCT LINES/BRANDS?

IF YOU WEAR AN SPF, WHAT IS THE LEVEL OF PROTECTION?

DO YOU SUNBATHE OR PARTICIPATE IN REGULAR OUTDOOR ACTIVITIES? ☐ YES ☐ NO

HAVE YOU HAD ANY DIRECT SUN EXPOSURE IN THE LAST 10 DAYS? ☐ YES ☐ NO

DO YOU TAN OR USE A TANNING BOOTH? ☐ YES ☐ NO

IF YES, HAVE YOU TANNED IN THE LAST 14 DAYS? ☐ YES ☐ NO

DO ANY OF YOUR PRODUCTS CONTAIN ANY OF THE FOLLOWING?

☐ BENZOYL PEROXIDE (BPO) ☐ GLYCOLIC ACID (AHA) ☐ LACTIC ACID (AHA)

☐ RETINOL ☐ RESCORCINOL ☐ HYDROQUINONE ☐ SALICYLIC ACID (BHA)

☐ OTHER:

ARE YOU CURRENTLY USING ANY OF THE FOLLOWING PRESCRIPTION PRODUCTS?

☐ TRETINOIN (RETINA, RETIN-A MICRO. RENOVA. AVITA) ☐ ADEPALENE (DIFFERIN)

☐ TAZAROTENE (TAZORAC) ☐ ISOTRETININOIN (ACCUTANE) ☐ TRILUMA

☐ METROGEL ☐ HYDROCORTISONE ☐ OTHER:

HAVE YOU EVER RECEIVED A PROFESSIONAL SKINCARE TREATMENT BEFORE? ☐ YES ☐ NO

IF YES, WHAT TYPE OF TREATMENT?

WHEN WAS YOUR LAST TREATMENT?

WHAT ARE YOUR SKINCARE GOALS?

TELL US ABOUT YOUR WELLNESS

PLEASE RATE YOUR LEVEL OF STRESS FROM 1-5 (5 BEING THE HIGHEST)

WITHIN THE LAST YEAR HAVE YOU BEEN UNDER THE CARE OF OR HAD:

☐ DERMATOLOGIST ☐ PHYSICIAN ☐ SURGERY

IF YES, PLEASE PROVIDE ADDITIONAL INFO (REASON FOR VISIT, AREA OF SURGERY) ____________________

IN THE LAST 14 DAYS HAVE YOU HAD ANY OF THE FOLLOWING?

☐ FACIAL COSMETIC SURGERY ☐ BOTOX INJECTIONS ☐ FILLERS

☐ COLLAGEN INJECTIONS ☐ LIGHT TREATMENTS ☐ LASER RESURFACING

☐ FACIAL ☐ MICRODERMABRASION ☐ DERMAPLANING

PLEASE CHECK ANY OF THE FOLLOWING THAT ARE APPLICABLE:

- ☐ CONTACT LENSES
- ☐ METAL IMPLANTS/PACEMAKER
- ☐ STROKE
- ☐ HIGH CHOLESTEROL
- ☐ VARICOSE VEINS
- ☐ ASTHMA
- ☐ COLD SORES/HERPES SIMPLEX
- ☐ LUPUS
- ☐ BRACES/DENTAL FILLINGS
- ☐ CANCER
- ☐ IRREGULAR HEARTBEAT
- ☐ ANEMIA
- ☐ EPILEPSY/SEIZURES
- ☐ TOBACCO USER/SMOKER
- ☐ RECENT DENTAL X-RAYS
- ☐ PIERCING(S)
- ☐ HEART ATTACK
- ☐ THYROID DISORDER
- ☐ DIABETES
- ☐ CLAUSTROPHOBIA
- ☐ HIGH/LOW BLOOD PRESSURE
- ☐ HEPATITIS
- ☐ OTHER: ____________________

HAVE YOU EVER HAD A REACTION OR ARE ALLERGIC TO ANY OF THE FOLLOWING:

- ☐ ASPRIN/SALICYLATES
- ☐ CITRUS
- ☐ LATEX
- ☐ MILK
- ☐ GRAPES
- ☐ APPLES
- ☐ FISH/MARINE OR IODINE
- ☐ INGREDIENTS IN SKINCARE/ COSMETIC PRODUCTS
- ☐ OTHER ____________________

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, NUTRITIONAL SUPPLEMENTS, ETC.? ☐ YES ☐ NO

PLEASE LIST ____________________

FEMALE CLIENTS ONLY, PLEASE CHECK ANY OF THE FOLLOWING THAT ARE APPLICABLE:

- ☐ ON HORMONE REPLACEMENT THERAPY
- ☐ PRESENTLY TAKING BIRTH CONTROL
- ☐ PREGNANT OR NURSING

I HAVE ACKNOWLEDGED THAT ALL THE INFORMATION PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT SOME SKIN CONDITINS MAY REQUIRE MORE THAN ONE TREATMENT AND HOMECARE PRODUCTS TO ACHIEVE THE RESULT DESIRED. RESULTS CANNOT BE GUARANTEED DUE TO INDIVIDUAL SKIN TYPE(S) AND CONDITIONS(S). I UNDERSTAND I NEED TO SIGN THIS WAIVER PRIOR TO EVERY TREATMENT PROVIDED, WITH ANY CHANGES PERTAINING TO THE ABOVE INFORMATION.

CLIENT SIGNATURE ____________________ DATE: __________

CLIENT SIGNATURE ____________________ DATE: __________

CLIENT SIGNATURE ____________________ DATE: __________