SKIN MEDICINAL

LUXURY SKIN HEALTH

Confidential Client Profile

Client Name (please print) _____ Date _____

Address _____ Apt. / Unit _____

City _____ State _____ ZIP _____

Date of Birth _____

Home Phone _____ ❍ Work / ❍ Mobile Phone _____ E-Mail Address _____

How did you hear of us? _____

The following profile is required to be completed by all clients. This analysis assists in correctly evaluating the client's individual skin care needs for spa treatments and home maintenance. This information is completely confidential and will be used for specified purposes only.

Client History

Within the last year, have you been under a dermatologist's or physician's care? ..... ❍ YES ❍ NO

Within the last nine months, have you undergone any surgery? ..... ❍ YES ❍ NO
If yes, please explain: _____

Have you had any health problems in the past or present? ..... ❍ YES ❍ NO
If yes, please explain: _____

List any medications, supplements, vitamins, that you take regularly: _____

Do you smoke? ..... ❍ YES ❍ NO

Do you exercise regularly? ..... ❍ YES ❍ NO

Do you follow a restricted diet? ..... ❍ YES ❍ NO
If yes, please explain: _____

Do you wear contact lenses? ..... ❍ YES ❍ NO

Do you have:
❍ metal implants ❍ a pacemaker ❍ body piercings?

Rate your level of stress on a scale of 1-4 (1=low / 4=high): _____

Are you prone to cold sores or fever blisters? ..... ❍ YES ❍ NO
If yes, what if any medication do you use? _____

Your Skin

Do you have any special skin problems pertaining to your face or body? ..... ❍ YES ❍ NO
If yes, please explain: _____

What skin care products are you currently using? What brand(s)?

Face:
❍ soap: _____
❍ cleanser: _____
❍ toner: _____
❍ exfoliator: _____
❍ moisturizer: _____
❍ masque: _____
❍ eye products: _____
❍ other: _____

Body:
❍ soap: _____
❍ shower gel: _____
❍ scrubs: _____
❍ oil: _____
❍ moisturizer: _____
❍ self tanners: _____
❍ depilatories: _____
❍ other: _____

What brand(s) of face makeup (foundation/powder) are you using? _____

Exfoliation History

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? ..... ❍ YES ❍ NO
If yes, please explain: _____

Do you use Accutane, Retin-A, Renova or any other prescription skin product? ..... ❍ YES ❍ NO

In the last three months? ..... ❍ YES ❍ NO
If yes, please explain: _____

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Exfoliation History, cont'd

Are you currently using any of the following products and/or ingredients?

❍ exfoliating scrubs ❍ Vitamin A derivatives (i.e. Retinol)
❍ any hydroxy acid product (ie. lactic, glycolic or salicylic acids)
❍ lightening or bleaching products

Moisture Hydration

How much plain water do you consume daily?_____

How many alcoholic beverages do you consume weekly? _____

Do you ever experience these conditions on your skin?
❍ Flakiness ❍ Tightness ❍ Obvious dryness

What SPF sunscreen do you use on your face?_____
What SPF sunscreen do you use on your body?_____

Do you sunbathe or use tanning beds?..... ❍ YES ❍ NO

Capillary Activity

Do you burn easily in moderate sunlight?..... ❍ YES ❍ NO

Do you blush easily when nervous?..... ❍ YES ❍ NO

Do you have a tendency to redness? ..... ❍ YES ❍ NO

Do you suffer from sinus problems? ..... ❍ YES ❍ NO

Oil Secretion

Do you ever experience oily shine during the day? ❍ YES ❍ NO

Do you ever experience skin breakouts?..... ❍ YES ❍ NO

Nerve Activity

How many caffeinated beverages do you drink per day?_____

How many carbonated beverages do you drink per day?_____

Do you ever experience a burning, itching sensation on your skin? ..... ❍ YES ❍ NO

Nerve Activity, cont'd

What is your pain threshold? ❍ Low ❍ Medium ❍ High

Have you ever experienced claustrophobia? ..... ❍ YES ❍ NO

What type of massage pressure do you prefer?
❍ Light touch ❍ Medium touch ❍ Firm touch

Allergens

Have you ever had a reaction to any of the following?

❍ cosmetics: _____ ❍ medicine: _____
❍ aspirin: _____ ❍ iodine: _____
❍ food: _____ ❍ hydroxy acids: _____
❍ animals: _____ ❍ fragrance: _____
❍ sunscreens: _____ ❍ other: _____

Female Clients only

Are you taking oral contraception? ..... ❍ YES ❍ NO

Are you pregnant or trying to become pregnant? .. ❍ YES ❍ NO

Are you lactating? ..... ❍ YES ❍ NO

Male Clients only

What is your current shaving system? _____

Do you experience irritation from shaving?..... ❍ YES ❍ NO

Do you experience ingrown hairs? ..... ❍ YES ❍ NO

Skin Care Goals

What are you skin care goals? _____

_____

_____

_____

_____

_____

_____

_____

_____

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

_____ _____
Client Signature Parent / Guardian Signature

_____ _____
Date Date