Skin Perfection

Client Intake Sheet

Name: _____ Birthdate: _____ /_____/ _____
Address: _____
Phone: (____) _____-_____ Email: _____

1. Have you been under the care of a physician or dermatologist within the last year? Yes No
   If yes, for what? _____
2. Have you had any surgical procedures within the last 6 months? Yes No
   If yes, for what? _____
3. Do you have any health problems such as cancer, diabetes, cardiovascular disease, allergies, or hormonal problems? Yes No
4. Do you have any metal implants or a pacemaker? Yes No
5. Do you travel frequently? Yes No
6. Are you on a restricted diet? Yes No
7. Are you currently pregnant or lactating? Yes No
8. Do you smoke? Yes No
9. Do you exercise regularly? Yes No
10. Do you get cold sores? Yes No
11. What is your water intake? _____ Servings per day
12. What is your caffeine intake? _____ Servings per day
13. What is your alcohol intake? _____ Servings per week
14. Please list any medications, both oral and topical, that you are currently taking: _____
    _____
    _____
15. Please list any known allergies: _____
16. Do you have any reactions to any topical treatments? Yes No
    If yes, for what? _____
17. What is your skin type? (Please circle all that apply)
    Normal/Dry Normal/Oily Dry Oily/Blemish-prone Combination Acne Rosacea Sensitive Mature Wrinkled Fine Lines Fair Skin Dark Skin Light/Medium Skin Discoloration Scarring Dermatitis:_____ Other: _____
18. Have you used Accutane, Retin A, Acids, or any other prescription topical medication on your skin in the last two years? Yes No
    If yes, what medication? _____
19. When was your last facial treatment? (Including facial, chemical peel, laser, waxing, microdermabrasion, etc)
    Date:_____ What kind of treatment did you receive? _____
20. Are you currently on an acne treatment? Yes No
    If yes, what are you using? _____
21. What is your current skin care regimen? Please include the manufacturer:
22. Cleanser: _____ Toner: _____
23. Exfoliates: _____ Moisturizer: _____
24. Eye/Lip: _____ Serum: _____
25. Sunscreen: _____ Other: _____
26. What are your skin concerns?_____
27. What is the purpose of your visit?_____