Please Print
Today's Date ____________________
First Name_______________________ Last Name_____________________ Date of Birth_____/_____/______
Street _________________________ City _________________________ State ______ Zip_______________
Phone- Home (_______) ____________ Work (____) ____________ Cell (_____) ________________
Dermatologist/ Physician ____________________________________ Phone (_____) ______________
Emergency Contact ____ Phone (_____) ______________
Your Occupation ____
Referred By ( )- Friend ( )- Mailer ( )- Walk-by ( )- Gift Certificate ( )- Web ( )- Other
Esthetician Name____

1. Is This your first Facial? ( )- Yes( )- No 2. What is the reason for your visit today? _______________________________	12. Are you now using (or used in the past). ( )-Differing ( )-Renovo ( )-Retina-A ( )-Tazarac ( )-Azelex ( )-Glycolic or Alphahydroxy acid If so, when and for how long? ________________
3. What special areas of concern do you have? _______________________________	13. Are you now using or have ever used Acutane? ( )- Yes ( )- No If so, when and for how long? ________________
4. Are you presently under a physician's care for any current skin conditions or other problem? ( )- Yes ( )- No What? _____________________________	14. Do you have acne? ( )-Yes ( )- No Experience frequent blemishes? ( )-Yes ( )-No If Yes, how frequently? _____________________
5. Are you pregnant? ( )- Yes ( )- No 6. Are you taking birth control pills? ( )- Yes ( )- No What type? _________	15. Do you have any allergies to cosmetics, food, or drugs? ( )- Yes ( )- No Please list_________________________________
7. Hormone replacement? ( )- Yes ( )- No What kind? _________ 8. Do you wear contact lenses? ( )-Yes ( )-No 9. Do you smoke? ( )- Yes ( )- No	16. Are you presently taking medications-oral or topical? ( )- Yes ( )- No If so, please list _____________________________ ____ ____
10. Do you often experience stress? ( )-Yes ( )-No 11. Have you had skin cancer? ( )- Yes ( )- No	17. What products do you use presently? ( )-Cleansing Milk ( )-Soap ( )-Toner ( )-Scrub ( )-Mask ( )-Creams ( )-Sunscreen ( )-Other

Please circle if you are affecter by or have any of the following:

Asthma	Hysteractomy
Cardiac problems	Immune Disorders
Eczema	Lupus
Epilepsy	Metal bones, pins, or plates
Fever blisters	Pacemaker
Headaches-chronic	Sinus problems
Hepatitis	Skin diseases- other
Herpes	Urinary or kidney problems
High blood pressure	

Please explain above problems or list any significant others: ____

I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential.

I fully understand and agree to the above salon policies.

Client Signature_________________________________ Date ____