

Client Information

Name: _____ Telephone: () _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

How did you hear about us? _____

Your health

Do you smoke? Yes / No

Do you exercise? Yes / No

How many alcoholic beverages do you consume weekly? _____

Do you follow a restricted diet? Yes / No

Please describe: _____

How much plain water do you consume each day? _____

Do you drink more than 4 caffeinated beverages a day? (tea, coffee, soda) Yes / No

Do you use tanning beds? Yes / No

Do you wear contact lenses? Yes / No

Rate your level of stress on a scale of 1 to 4 (1 = low, 4 = high) _____

Your skin

What improvements would you like to see in your skin? _____

What are you currently using to cleanse your face? _____

What are you currently using to moisturize? _____

Special treatments? (night creams, eye creams, masques?) _____

Do you use Accutane, Retin A, Renova, or any other prescription skin products? Yes / No

Have you ever had any chemical peels or microdermabrasion? Yes / No

What SPF sunscreen do you use on your face? _____

Do you ever experience flakiness, tightness, or dryness on your skin? Yes / No

Do you ever experience any itching, redness, or sensitivity? Yes / No

Do you ever experience oily shine throughout the day? Yes / No

Do you ever experience breakouts? Yes / No

Do you use any exfoliating products? Yes / No

Signature _____ Date _____