SKIN CARE CONSULTATION FORM

PATIENT/CLIENT INFORMATION

DATE_____

NAME_____

ADDRESS_____

_____

REASON FOR CONSULTATION_____

_____

_____

_____

SKIN TYPE AND CONCERNS

____NORMAL

____DRY

____OILY

____ACNE

____DEHYDRATED

____FINE LINES

____HYPO/HYPER PIGMENTATION

____COMEDONES

____MILLIA

____BROKEN CAPILLARIES

____SCARS

____WRINKLES

OTHER_____

HEALTH CONDITIONS

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? Y____ N____ DO YOU SMOKE? Y____ N____

DO YOU USE RETIN-A? Y____ N____ FOR HOW LONG?_____

HAVE YOU EVER USED ACCUTANE? Y____ N____ FOR HOW LONG?_____

KNOWN ALLERGIES_____ MEDICATIONS_____

ANY CHRONIC PROBLEMS_____

SKIN CONDITIONS

____ROSACEA ___COLD SORES ____ECZEMA ____PSORIASIS ____WARTS

____DERMATITIS ___RECENT RADIATION OR CHEMOTHERAPHY TREATMENT ____RECENT SURGERY (DATE)

OTHER_____

CURRENT TREATMENTS (DATE OF LAST PROCEDURE)

ELECTROLYSIS_____ LASER_____ CHEMICAL PEEL_____ WAXING_____

MICRODERMABRASION_____ DEPILATORIES_____ SURGERY_____

OTHER_____

TREATMENT PLAN (TO BE COMPLETED BY PHYSICIAN/ESTHETICIAN)

MORNING

CLEANSER:_____

TONER:_____

MOISTURIZER:_____

TREATMENT:_____

MASK:_____

EVENING

CLEANSER:_____

TONER:_____

MOISTURIZER:_____

TREATMENT:_____

MASK:_____

OTHER:_____

TOPICAL TREATMENT PLAN:_____

_____

PROFESSIONAL IN-CLINIC-SPA TREATMENT PLAN:_____

_____

_____ _____

ESTHETICIAN / PHYSICAN SIGNATURE DATE CLIENT SIGNATURE DATE