

Face Treatment Consultation Card

Client Name _____
Last First

Date: _____

If under 18, please provide your age _____

under 21 21 – 30 31 – 40 41-50 51-60 60+

Your Health

1. Within the last year, have you been under a dermatologist or other physician's care? yes no
2. Within the last nine months, have you undergone any surgery? yes no
if yes, please specify _____
3. Have you had any health problems in the past or present? yes no
if yes, please specify _____
4. List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly _____
5. Do you smoke? yes no
6. Do you exercise regularly? yes no
7. Do you follow a restricted diet? yes no
8. Do you wear contact lenses? yes no
9. Do you have metal implants, a pacemaker or body piercings? yes no
10. Rate your level of stress on a scale of 1 to 4 (1=low stress, 4=high stress) _____

Your Skin

11. Do you have any special skin problems pertaining to your face or body? yes no
if yes, please specify _____
12. What skin care products are you currently using?
Face: soap cleanser toner moisturizer masque exfoliator eyeproducts
Body: soap shower gel scrubs oil body moisturizer depilatory product self tanners

Exfoliation history

13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?
 yes no in the last 3 months? yes no
14. Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products?
 yes no in the last 3 months? yes no
15. Are you currently using any products that contain the following ingredients?
 glycolic acid lactic acid any exfoliating scrubs any hydroxy acid product
 vitamin A derivatives (i.e. retinol)

Moisture hydration

16. How much plain water do you consume daily? _____
17. How many alcoholic beverages do you consume weekly? _____
18. Do you ever experience these conditions on your skin? flakiness tightness obvious dryness
19. What spf sunscreen do you use on your face? _____ Body? _____
20. Do you sunbathe or use tanning beds? yes no

Capillary activity

21. Do you burn easily in moderate sunlight? yes no
22. Do you blush easily when nervous? yes no
23. Do you have a tendency to redness? yes no
24. Do you suffer from sinus problems? yes no

Oil secretion

25. Do you ever experience oily shine during the day? yes no occasionally
26. Do you ever experience skin breakouts? yes no occasionally

Nerve activity

27. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) yes no
28. Do you ever experience a burning, itching sensation on your skin? yes no
29. What is your pain threshold? low medium high
30. Have you ever experienced claustrophobia? yes no
31. What type of massage pressure do you prefer? light medium firm
32. Have you ever had a reaction to any of the following?
- cosmetics medicine iodine pollen food hydroxy acids animals fragrance
- sunscreens other _____

Female clients only

33. Are you taking oral contraception? yes no
34. Are you pregnant or trying to become pregnant? yes no
35. Are you lactating yes no

Male clients only

36. What is your current shaving system? electric wet shave
37. Do you experience irritation from shaving? yes no
38. Do you experience ingrown hairs? yes no

Questions to discuss every visit

39. Are you currently having or due for your menstrual period? yes no
40. Have you started any new medication since your last visit? yes no
41. Have you had any recent dental x-rays? yes no
42. What are your skin care goals? _____
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