Integrative Skincare Form

NAME: ______________________________ PHONE NUMBER: ____________________

ADDRESS: __________________________ DATE OF BIRTH:______________________

__________________________ EMAIL: _______________________________

Have you been treated for any of the following conditions?

______ Acne ______ Diabetes ______ Keloid Formation
______ Arthritis ______ Epilepsy ______ Shingles
______ Asthma ______ Heart Condition ______ Skin Cancer
______ Blood Disorders ______ Herpes ______ Stomach Ulcers
______ Burns/Skin Grafts ______ High Blood Pressure ______ Thyroid Problem
______ Cancer (Radia./Chemo) ______ Hirsutism ______ Varicose Veins
______ Dermal Abrasions ______ Hormone Imbalances ______ Vitiligo

-Are you currently under the care of a Dermatologist or any other Doctor? YES / NO
Please explain:____

-Are you being treated for any other chronic medical condition not listed? YES / NO
Please explain:____

-Do you have any allergies? (Including food allergies) YES / NO
Please Explain:____

-Are you currently using any medications, topical or oral? (Including Accutane, Retin A, Differin, Benzoyl Peroxide, Cortisone Cream, Metrogel, Antibiotics, Tetracycline, Glycolic Acid, Alpha or Beta Hydroxy Acids? YES / NO
Please explain:____

-Do you have any skin sensitivity? YES / NO
Please explain:____

-Is there any possibility that you are currently pregnant? YES / NO

-Do you have any metal objects in your body (pins, plates, or piercings)? YES / NO
Please explain: ____

-What is your current skin care routine? List brand where known.

Face Soap/Cleanser: ____________________

Toner: ____________________

Daily Moisturizer: ____________________

SPF: ____________________

Exfoliator/Scrub: ____________________

Mask: ____________________

Eye Product: ____________________

Night Cream: ____________________

Other:

____

-What areas of concern do you have regarding your skin?

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____

Client Signature: ______________________________

Date: ____________________

Please note that clients under the age of 18 must have proven parental consent prior to treatment.
Parent/Guardian Signature:

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