Skin Care Consultation Form

Client information	
Patient name:	Date of birth:
Sex:	Gender:
Marital status:	Patient ID:
Address:	
Email:	Contact number:
Emergency contact	
Full name:	
Relationship:	
Contact information:	
Insurance information (if applicable)	
Insurance carrier:	
Insurance plan:	
Policy number:	Contact number:
Group number:	Social security number:
Skin care	
Skin care goals:	
Skin care challenges:	

- Wrinkles/fine lines
- Acne/acne scarring
- Aging
- Sensitivity
- Hyperpigmentation/sun damage
- Redness/rosacea
- Melasma
- Other:

Current skin condition diagnosis (if applicable):

Have you ever had a facial or skin treatment before? Yes No

If yes, what treatments have you had:

Skin care products you currently use (if yes, please state the brand):

Cleanser/face wash:

Toner:

Sunscreen:

Bar soap:

Serums:

Eye product(s):

Face scrub/exfoliants:

Moisturizer:

Lip product(s):

Other:

Have you received hair removal services? Yes No

If yes, how long ago, and please describe:

Have you received chemical peels, lasers, or microdermabrasion treatments? Yes No

If yes, how long ago, and please describe:

Have you received Botox, Juvederm, or dermal fillers? Yes No

If yes, how long ago, and please describe:

Additional notes:

Health

Please list any current medical diagnosis you have:

Please list any current medications (oral/topical) you are taking:

Please list any current allergies you have:

Tick the box if you're wearing any of the following:

- Contact lenses
- Pacemaker
- Body piercings
- Metal implants
- Other:

Do you take any of the following supplements?

- Multivitamin
- Vitamin C
- Vitamin D/D3
- Melatonin
- Zinc
- Omega 3/fish oil
- B Complex/B12
- Coenzyme Q10
- Garlic
- Calcium
- Folic acid
- Biotin
- Other:

Are you taking any birth control? Yes No

If yes, please specify:

Are you pregnant, trying to become pregnant, or just had a baby? Yes No

Are you menopausal and experiencing any issues? Yes No

If yes, please elaborate:

Are you undergoing hormone replacement therapy? Yes No	
If yes, please elaborate:	
Do you shave? Yes No	
If yes, what is your current preferred method of shaving:	
Are you experiencing any irritation from shaving? Yes No	
Tick the boxes if you do any of the following (if yes, please state how often):	
Smoke: Drink alcoholic beverages: Drink caffeinated beverages:	
Additional information	
Client's signature:	**Date:**