Name: Last__________________________________ First_______________________________________ MI___________

Address: Street____________________________________ City___________________ State_________ Zip___________

Cell Phone______________________ Home Phone____________________ Email__________________________________

Date of Birth____________ Emergency Contact_________________________________ Number____________________

Occupation________________ Place of Employment____________________ How did you hear about us?____________

How often do you receive facials? 1 x a month 2 x a month other: _______ When was your last facial? ____________

What prevents you from receiving regular facials? Time Cost Convenience Other: __________________________

Is this a Gift? ☐ Yes ☐ No Are you active Military ☐ Yes ☐ No Are you enrolled in a HAS, FSA, or HRA ☐ Yes ☐ No

Within the last year, have you been under a dermatologist's or other physician's care?

☐ Yes ☐ No If yes, please explain: ____

Have you had any health problems in the past? ☐ Yes ☐ No If yes, please explain: _________________________________

List any medications, supplements, vitamins, diet pills, Isotretinoin, etc. that you take regularly: ____________________

____

Please circle if you have any of these skin health concerns:

Premature Aging Uneven Skin Tone Breakout Oiliness Congestion General Healthy Skin

What are your specific concerns/challenges with your skin? ____

Do you smoke? ☐ Yes ☐ No Do you exercise regularly? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No

Do you have metal implants, a pacemaker or body piercings? ☐ Yes ☐ No

Rate your level of stress on a scale of 1 to 5 (1 = low stress, 5 = high stress) 1 2 3 4 5

Do you have any allergies? ☐ Yes ☐ No If yes, please list: ____

Do you sunbathe or use tanning beds? ☐ Yes ☐ No Do you drink more than 4 caffeinated beverages daily? ☐ Yes ☐ No

Have you had Botox or fillers within the last week? ☐ Yes ☐No Have you had surgery within the last 6 months? ☐Yes ☐No

Circle the skin care products that you are currently using for your face?

Soap Cleanser Toner Moisturizer Masque Exfoliator Eye products serum

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? ☐ Yes ☐ No In the last month? ☐ Yes ☐ No

Do you use Retin-A , Renova, Adapalene or any other prescription skin products? ☐ Yes ☐ No In the last 3 months? ☐ Yes ☐ No

Are you currently using any products that contain the below ingredients? ☐ Yes ☐ No

Glycolic acid, lactic acid, any exfoliating scrubs, salicylic acid, and/or vitamin A derivatives (i.e., Retinol)

Have you waxed any area of your face within the last 72 hours? ☐ Yes ☐ No if Yes, where? ________________________

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

What SPF sunscreen do you use on your face? ____________ Do you burn easily in moderate sunlight? ☐ Yes ☐ No

Do you have a tendency to redness? ☐ Yes ☐ No Do you suffer from sinus problems? ☐ Yes ☐ No

Do you ever experience burning, itching, or stinging sensations on your skin? ☐ Yes ☐ No

If Yes, please specify: ____

Female Guests Only: Are you taking oral contraception? ☐ Yes ☐ No Are you pregnant or trying to be pregnant? ☐ Yes ☐ No

Are you currently nursing? ☐ Yes ☐ No Are you currently having or due for your menstrual cycle? ☐ Yes ☐ No

Guest please initial: _________________________