The Healing Garden
mend the body, nurture the soul

Skin Care Consultation

Date: ____________________

Name: ____________________ Date of Birth____________________

Occupation: ____________________

Does your job require that you work out of doors? **Yes** **No**

What would you like to achieve from your treatment today?

____

____

____

Tell us about Your Skin Care:

Have you ever had a facial treatment before? **Yes** **No** When? ____________________

Which of the following best describes your skin type?

I	Creamy complexion	*Always burns, never tans*
II	Light Complexion	*Always burns, tans slightly*
III	Light/Matte complexion	*Burns moderately, tans gradually*
IV	Matte complexion	*Seldom burns, always tans well*
V	Brown complexion	*Rarely burns, deep tan*
VI	Dark brown complexion	*Rarely burns, deeply pigment*

Do you have any special skin problems or concerns pertaining to your face or body? **Yes** **No**

Specify: ____________________

Have you ever had chemical peels, laser or microdermabrasion? **Yes** **No**

In the last month? **Yes** **No**

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products?

Yes **No** Describe: ____

Have you used any of these products in the last month? **Yes** **No**

Have you used acne medication? **Yes** **No** When? ______________ Which drug? ________________

Please specify all products that you use in your skin care:

Soap	Toner
Mask	Eye product
Cleanser	Daily Moisturizer
Exfoliator	Scrubs
Shower Gel	Body Lotions
Sunscreen	SPF
Night Moisturizer/Cream	Other
Makeup Products	

What skin care products are you currently using? (List brands) ______________________________

____

Have you recently used any self-tanning lotions, creams or treatments? **Yes** **No**

Specify: ____

Have you used any of the following hair removal methods in the past six weeks?

Yes **No** (Circle all that apply):

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

What areas of concern do you have regarding your skin: (Please check any that apply and explain)

Breakouts/Acne
Blackheads/Whiteheads
Rosacea
Broken Capillaries
Redness/Ruddiness
Sun Spot/Liver Spot/ Brown Spot
Uneven Skin Tone
Sun Damage
Dull/ Dry Skin
Flaky Skin
Dehydrated
Other

Eyes:

Dehydrated Wrinkles Puffiness Dark Circles Other:

Lips:

Dehydrated Cracked/Chapped Other:

Have you ever had an allergic reaction to any of the following? (If yes please explain)

Cosmetics
Medicine
Food
Shellfish
Sunscreens
Iodine
Other
Alpha Hydroxy Acids
Fragrance
Animals
Latex
Drugs
Pollen

Explain: ____

What SPF do you use on your face? ____________ How often/when? ____________________

What SPF do you use on your body? ____________ How often/when? ____________________

Have you had any recent tanning bed or sun exposure that changed the color of your skin? **Yes** **No**

Specify: ____

Female clients:

Are you taking oral contraceptives? **Yes No**

Specify: ____

Any recent changes to your contraceptive treatment? **Yes No**

Are you pregnant or trying to become pregnant? **Yes No**

Are you lactating? **Yes No**

Any menopause problems? **Yes No**

Specify: ____

Are you undergoing any hormone replacement therapy? **Yes No**

Specify: ____

Male Clients:

What is your current shaving system? Wet Shave Electric

Do you experience irritation from shaving? **Yes No** Ingrown hairs? **Yes No**

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: ____ **Date:**____________________

Print Name: ____