



Client's Profile

Name		Age	Sex	Date
Address		Phone		
Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you currently have <input type="checkbox"/> sunburn <input type="checkbox"/> windburn	Do you go to tanning booths <input type="checkbox"/> yes <input type="checkbox"/> no		
Do you get facial waxing / electrolysis / or use depilatories?	<input type="checkbox"/> yes, wait approximately 5 days between treatments <input type="checkbox"/> no			
Have you had collagen injections recently	<input type="checkbox"/> yes, wait approximately 7 days between treatments <input type="checkbox"/> no			
Do you participate in vigorous aerobic activity or sport? <input type="checkbox"/> yes <input type="checkbox"/> no				
Have you ever had a peel before? <input type="checkbox"/> yes <input type="checkbox"/> no	Within the last 14 days?		<input type="checkbox"/> yes <input type="checkbox"/> no	
Describe your reaction				
Are you recently post-operative? <input type="checkbox"/> yes, from _____ <input type="checkbox"/> no				
Are you allergic to <input type="checkbox"/> milk <input type="checkbox"/> apples <input type="checkbox"/> citrus <input type="checkbox"/> grapes <input type="checkbox"/> aloe vera <input type="checkbox"/> aspirin <input type="checkbox"/> hydroquinone				
Any other allergies? Describe				
Describe your skin <input type="checkbox"/> normal <input type="checkbox"/> oily <input type="checkbox"/> dry <input type="checkbox"/> T-zone / combination <input type="checkbox"/> freckled <input type="checkbox"/> sun damaged <input type="checkbox"/> uneven / blotchy <input type="checkbox"/> mature <input type="checkbox"/> wrinkled <input type="checkbox"/> saggy <input type="checkbox"/> firm <input type="checkbox"/> large pores <input type="checkbox"/> small pores <input type="checkbox"/> acne <input type="checkbox"/> milia <input type="checkbox"/> comedones <input type="checkbox"/> occasional breakouts <input type="checkbox"/> scarred <input type="checkbox"/> cystic <input type="checkbox"/> melasma <input type="checkbox"/> florid <input type="checkbox"/> rosacea <input type="checkbox"/> asphyxiated <input type="checkbox"/> sallowness <input type="checkbox"/> perfume-stained <input type="checkbox"/> hypopigmented <input type="checkbox"/> hyperpigmented				
Do you consider your skin <input type="checkbox"/> sensitive <input type="checkbox"/> resilient				
Eye color <input type="checkbox"/> blue <input type="checkbox"/> green <input type="checkbox"/> hazel <input type="checkbox"/> grey <input type="checkbox"/> light brown <input type="checkbox"/> dark brown				
Hair color <input type="checkbox"/> blonde <input type="checkbox"/> red <input type="checkbox"/> light brown <input type="checkbox"/> medium brown <input type="checkbox"/> dark brown <input type="checkbox"/> black <input type="checkbox"/> grey / silver				
Skin tone <input type="checkbox"/> pale / white <input type="checkbox"/> light <input type="checkbox"/> reddish / freckles <input type="checkbox"/> light olive <input type="checkbox"/> medium olive <input type="checkbox"/> dark olive <input type="checkbox"/> brown <input type="checkbox"/> black				
What is your heritage?				
Are you using <input type="checkbox"/> Retin A; how frequently? _____ Where do you apply it? _____ <input type="checkbox"/> Accutane <input type="checkbox"/> hormones / other medications _____ <input type="checkbox"/> glycolic / AHA home care products _____ How is your skin reacting to them? _____				
Have you ever used any product that caused a bad reaction? Describe.				
Do you <input type="checkbox"/> smoke <input type="checkbox"/> get cold sores / fever blisters <input type="checkbox"/> have telangiectasia / broken surface capillaries				
What is your home regiment?				
What about your skin bothers you, and what would you like to have corrected?				
Esthetician's treatment recommendations				
Esthetician's signature				