Shelley's Day Spa & Salon Skincare Facial Intake Form

Name:____ Mobile# _________________________________

Address:_______________________________________City:____________State: ____________________

DOB:_____/____/_____Email Address: ____

Emergency Contact:_______________________________________Phone: __________________________

Referred By: ____

EXPECTATIONS AND HISTORY

1. Which conditions would you like to improve?

___Acne Scarring ___Hyperpigmentation ___Acne ___Broken Capillaries ___Age Spots

___Stretch Marks ___Enlarged Pores ___Surgical/Facial Scars ink Fine Lines & Wrinkles

Other:____

2. Have you ever had a facial treatment in the past Y ___N If yes explain:_________________________

3. What special areas of concern do you have?____________________________________

4. What is the reason for your visit today?_____________________________________

5. What is your Ethnic Background?_______________________________________

6. Do you ever experience CHECK ALL THAT APPLY
Flakiness_____Tightness______Redness_____Excessive Oily Shine during Day

7.What is your present Skin Regimen? CHECK ALL THAT APPLY

___Soap & Water ___Cleanser ___Toner ___Mask Moisturizer ___Exfoliation ___Sun Block DAILY
Other:____

8. Do you blush easily ___Y ___N

9. Do you CHECK ALL THAT APPLY ___Sun Bathe ___Use a Tanning Bed

10. Have you ever had CHECK ALL THAT APPLY Peels Microdermabrasion ___Facial Surgery
___Botox ___Cosmetic Fillers_____Laser Resurfacing_____How Recently?____________________________

11. Are you under treatment for any current skin conditions?____

12. Does your skin heal ___Fast ___Scar ___Pigment ___Keloids

13. Do you bruise easily? ___Y ___N

14. Do you get fever blisters? ___Y ___N

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15. What medications/ hormone replacement/ vitamins do you presently take?
____

16. Have you ever used ___Accutane ___Retin A ___Renova ___Tropical Antibiotics ___Tazarac ___Alpha Hydroxy Acid

17. Any personal or family history of skin cancer? ___Y ___N

Allergies ___Y ___N
When/What____

Arthritis ___Y ___N

Blood Pressure __Y __N Check one __High __Low __Normal

Eczema ___Y ___N Where on the body?___________________

Cancer ___Y ___N

Cataracts ___Y ___N

Cholesterol ___Y ___N

Menopausal ___Y ___N

Varicose Veins ___Y ___N

Contact Lenses ___Y ___N

Epilepsy ___Y___ N

Heart Disease ___Y ___N

Infections ___Y ___N

Pace Maker ___Y ___N

Smoker ___Y ___N

Have you had a reaction to ___Cosmetics ___Metals ___Medication ___ Food ___Fragrance ___Air Borne Particles Other? ____________________________

FOR WOMEN Are you pregnant? ___Y ___N Do you experience hormone imbalances? ___Y ___N

FOR MEN Do you shave with ___Electric Shaver ___Razor

Do you experience skin breakouts? ___Y ___N
How many glasses of water do you consumer daily? ___
How many cups of caffeinated beverages do you consume daily? (coffee, tea, soft drinks) _________

Your technician will recommend the appropriate schedule for future skincare treatments and professional at home care in order to achieve your skin improvements goals.

Please sign below to acknowledge all information is true and correct.

Signature:____Date: _______________

Print: ____