

**PROFESSIONAL**

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**2007**

# Skin Care Client Profile & History

In order to provide you with the best possible services. . . . . please complete the following:

Client's Name \_\_\_\_\_

Therapist \_\_\_\_\_ Date \_\_\_\_\_

Bus: Ph. ( ) \_\_\_\_\_ Res: Ph. ( ) \_\_\_\_\_

What is your daily consumption of: Water \_\_\_\_\_ Oz. Coffee \_\_\_\_\_ Oz.

Address: \_\_\_\_\_

Tea \_\_\_\_\_ Oz. Soft Drinks (Diet/Reg) \_\_\_\_\_ Oz. Other \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

What water temperature do you cleanse with?  Cold  Warm  Hot

Birth Date: Month \_\_\_\_\_ Day \_\_\_\_\_

Skin Condition?  Dry  Oily  Unremarkable \_\_\_\_\_

**MEDICAL:** Are you currently or within the last year under ANY Doctors care?  NO  YES? Explain: \_\_\_\_\_

Any special skin problems?  Flaking  Tightness  Other \_\_\_\_\_

Have you ever had a reaction to any treatments?  NO  YES? \_\_\_\_\_

**Health Problems:** Diabetes, Thyroid, Heart, Cancer, Hysterectomy,

Do you ever experience any skin break out?  NO  YES? \_\_\_\_\_

Hormone imbalance, Epilepsy, Diet, Other: \_\_\_\_\_

Does PABA affect you in any way?  NO  YES? \_\_\_\_\_

**Medications, Drugs & Vitamins:** (List All & Why?) \_\_\_\_\_

Personal skin care now?  Soap  Cleanser  Toner  Scrub

Retin-A  Accutane  Diet Tablets  Smoke  Stimulants

Masque  Moisturizer  Other: \_\_\_\_\_

Oral Contraceptives  Laxatives  Diuretics  Other: \_\_\_\_\_

Do you? Blush easily  NO  YES? Sunburn  NO  YES? SPF# \_\_\_\_\_

Have you undergone any surgery?  NO  YES?

Redness Tendency  NO  YES? Massage Preference?  Firm  Light

Have you had any X-Rays Recently?  NO  YES?  Dental

Sinus Problems?  NO  YES? Pain Threshold  Low  Medium  High

Do you have any metal implants?  NO  YES? Explain: \_\_\_\_\_

Do you have reactions to:  Cosmetics  Metals  Pollen  Foods  Animals

How many hours a day do you work? \_\_\_\_\_ Other? \_\_\_\_\_ Total \_\_\_\_\_

**FEMALE CLIENTS ONLY:** Are you pregnant or trying to be?  NO  YES?

Do you sleep and exercise regularly?  NO  YES? Explain: \_\_\_\_\_

Are you taking oral contraception?  NO  YES? \_\_\_\_\_

REMARKS \_\_\_\_\_

Are you due for your menstrual period within the next week?  NO  YES?

Who was your last skin therapist? \_\_\_\_\_

Who Referred you? \_\_\_\_\_

Stylist \_\_\_\_\_ Nail Tech \_\_\_\_\_