

## Skin Care Evaluation Intake



Name (Please print):

When you go out in the sun do you?

**Always Burn**      **Usually Burn**      **Sometimes Burn**      **Rarely Burn**      **Never Burn**

Your Skin Care

Have you ever had a facial?

If yes, when was your last one?

Do you use: (and how often)

**Toner**    **Moisturizer**    **SPF (Sunscreen)**    **Exfoliant**      **Soap**    **Body Lotion**    **Shower Gel**  
**Scrubs**    **Mask**      **Eye Cream**      **Cleanser**      **Other**

What Skin care product brands are you using?

Are you taking any medications, supplements, herbs, o.t.c medications or homeopathic remedies?

(please list or give description)

Have you ever been treated for cancer? (How long ago and what type?)

Do you take any acne medication? (please list)

Do you currently or in the last 12 months used any products containing Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derived?

Are you using any Salicylic or Glycolic Acid?

Do you have any allergies or sensitivities? (please list)

Are you wearing contacts?

Do you have anything metal in your body (ie. Fillings, medical equipment, piercing, etc)? (Please explain)

Have you had a chemical peel, waxing, microdermabrasion, or laser treatments? Last treatment?

Have you currently done any self-tanning lotion, creams, or treatments?

Been tanning or had exposure to sun that changed skin tone?

Have you had any negative or adverse reaction to a cosmetic service?

Please list any medical issue you have:

In the past 6 weeks have you used any of the following hair removal methods (please circle all that apply)

**Waxing**    **Stringing**      **Sugaring**      **Shaving**    **Plucking/Tweezing**      **Electrolysis**      **Depilatories**

What issues do you have regarding your skin? (Check all that apply)

**Acne/Breakouts**    **Uneven Skin Tone**      **Dehydration**      **Wrinkles/Fine Lines**      **Blackheads/Whiteheads**  
**Excessive Oil/Shine**      **Dull/Dry Skin**      **Flaky Skin**      **Redness Sensitivity**      **sun/brown/liver spot**      **Roseacea**  
**Other**

Eyes:

**Dehydrated    Puffy    Dark Circles    Wrinkles    Other**

Lips:

**Dry/Cracked    Dehydrated    Other**

Have you recently had Botox, Collagen, or Restylane injections?

Are you currently under the care of a healthcare provider, skin care professional, dermatologist? What are you being seen for?

How much water do you consume a day?

Do you exercise on a regular basis? (How Often?)

Do you Smoke? (How much/often)

How many caffeinated beverages do you consume a day?

Do you have a tendency for:

**Bruising    Hyperpigmentation    Scarring Bumps    Ingrown Hairs    Other**

**Female Clients Only:**

Are you on any contraception? (please list)

Are there any recent changes to your contraception?

When is your next menstrual cycle supposed to start?

Are you pregnant or trying to become pregnant?

Are you lactating?

Are you experiencing any hormonal or menopausal issues or doing any hormonal treatments?

**Male Clients Only:**

What is your current shaving method? **Wet Shave    Electric Shave**

Do you experience any irritation or ingrown hairs from shaving?

I have answered these questions honestly and to the fullest extent of my ability. I understand that my treatment is of a cosmetic in nature and the decision to proceed is biased only on my expressed desire to do so. In accordance with the law, Esthetician/Skin Care Therapy can not diagnose, treat, prevent, or cure any condition. These sessions are used as regimens to help improve skins health and appearance. I understand that individual results may vary and that I do not hold BodyWorks Wellness Spa or its employees responsible for any experience I may have. Information exchanged in the session is done so at my own discretion. I agree to keep BodyWorks and my treatment provider up to date on all health and medical information as it changes. I will inform the service provider of any discomfort at the time of service. We reserve the right to refuse service to anyone at any time.

By signing below you agree the that you have read, acknowledge, and agree to the above statements

Signature:

Date:

Parent or Guardian Signature (If Client is under 18):

Date: