Skin Care Consultation Form

Client Information

First Name	Last Name	Preferred Name	Patient ID
Hayley	Grenier	Hayley	9483
Gender	**Preferred Pronouns**	**Date of Birth**	**Marital Status**
Female	She/her	03/07/1995	Unmarried

Address	City	State	Zip Code
123 Anywhere St, Green Oak	Boston	MA	2948

Email	Preferred Phone Number
example@email.com	009 0984

Emergency Contact

Full Name	Relationship	Contact Number
Melissa Grenier	Mother	048 4832
Jared Grenier	Father	029 9665

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Health4U	Plan B	007 0439
Policy Number	**Group Number**	**Social Security Number**
9483759	938	000 00 0000

Skin Care

What are your skin care concerns?

- ☐ Wrinkles/Fine Lines
- ☐ Hyperpigmentation/Sun Damage
- ☑ Acne/Acne Scarring
- ☐ Redness/Rosacea
- ☐ Aging
- ☐ Melasma
- ☐ Sensitivity
- ☐ Other:

Current skin condition diagnosis (if applicable)

Have you had skin care treatments before?

No

What skin care products do you currently use?

- ☑ Cleanser/Face Wash
- ☐ Bar Soap
- ☐ Face Scrub/Exfoliants
- ☐ Toner
- ☐ Serums
- ☑ Moisturizer
- ☐ Sunscreen
- ☐ Eye Product(s)
- ☐ Lip Product(s)

Please list the product names:

Cetaphil Oily Skin Cleanser, Cetaphil SPF25+ Daily Moisturizer for Acne Prone Skin

Have you received hair removal services? If so, please describe

No

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Skin Care (Continued)

Have you received chemical peels, lasers, or microdermabrasion treatments? If so, please describe

N/a

Have you received any Botox, Juvederm, or dermal fillers? If so, please describe

N/a

Do you wear...

Contact Lenses	☐ Yes	☒ No	Body Piercings	☐ Yes	☒ No
Pacemaker	☐ Yes	☒ No	Metal Implants	☐ Yes	☒ No

Do you take any of the following supplements?

☐ Multivitamin	☐ Zinc	☐ Garlic
☑ Vitamin C	☐ Omega 3/Fish Oil	☐ Calcium
☐ Vitamin D/D3	☐ B Complex/B12	☐ Folic Acid
☐ Melatonin	☐ Coenzyme Q10	☐ Biotin
☐ Other:		

On a scale of 1(best) to 5(worst), what is your current stress level?

☐ 1 ☐ 2 ☒ 3 ☐ 4 ☐ 5

Do you drink any caffeinated beverages? ☒ Yes ☐ No

Are you taking any birth control? If so, please specify

N/a

Do you shave? ☒ Yes ☐ No Are you experiencing irritations? ☐ Yes ☒ No

Please list any current medications

N/a

Please list any current medical diagnosis

Asthma

Please list any current allergies

Coconut

Signature of Client	Date
	22.12.2022