Skin Care Consultation Form

Client Information

First Name	Last Name	Preferred Name	Patient ID
Gender	Preferred Pronouns	Date of Birth	Marital Status

Address	City	State	Zip Code

Email	Preferred Phone Number

Emergency Contact

Full Name	Relationship	Contact Number
Full Name	Relationship	Contact Number

Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Policy Number	Group Number	Social Security Number

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?

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:

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

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Skin Care (Continued)

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

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

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

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

Please list any current medications

Please list any current medical diagnosis

Please list any current allergies

Signature of Client	Date