# Skin Care Consultation Form

| Client information | |
|---|---|
| **Patient name:** | **Date of birth:** |
| **Sex:** | **Gender:** |
| **Marital status:** | **Patient ID:** |
| **Address:** | |
| **Email:** | **Contact number:** |
| **Emergency contact** | |
| **Full name:** | |
| **Relationship:** | |
| **Contact information:** | |
| **Insurance information (if applicable)** | |
| **Insurance carrier:** | |
| **Insurance plan:** | |
| **Policy number:** | **Contact number:** |
| **Group number:** | **Social security number:** |
| **Skin care** | |
| **Skin care goals:** | |
| | |
| **Skin care challenges:** | |

- ☐ Wrinkles/fine lines
- ☐ Acne/acne scarring
- ☐ Aging
- ☐ Sensitivity
- ☐ Hyperpigmentation/sun damage
- ☐ Redness/rosacea
- ☐ Melasma
- ☐ Other:

**Current skin condition diagnosis (if applicable):**

**Have you ever had a facial or skin treatment before?** ◯ Yes ◯ No

If yes, what treatments have you had:

**Skin care products you currently use (if yes, please state the brand):**

- ☐ Cleanser/face wash:
- ☐ Toner:
- ☐ Sunscreen:
- ☐ Bar soap:
- ☐ Serums:
- ☐ Eye product(s):
- ☐ Face scrub/exfoliants:
- ☐ Moisturizer:
- ☐ Lip product(s):
- ☐ Other:

**Have you received hair removal services?** ◯ Yes ◯ No

If yes, how long ago, and please describe:

**Have you received chemical peels, lasers, or microdermabrasion treatments?** ◯ Yes ◯ No

If yes, how long ago, and please describe:

**Have you received Botox, Juvederm, or dermal fillers?** ◯ Yes ◯ No

If yes, how long ago, and please describe:

**Additional notes:**

**Health**

**Please list any current medical diagnosis you have:**

**Please list any current medications (oral/topical) you are taking:**

**Please list any current allergies you have:**

**Tick the box if you're wearing any of the following:**

- [ ] Contact lenses
- [ ] Pacemaker
- [ ] Body piercings
- [ ] Metal implants
- [ ] Other:

**Do you take any of the following supplements?**

- [ ] Multivitamin
- [ ] Vitamin C
- [ ] Vitamin D/D3
- [ ] Melatonin
- [ ] Zinc
- [ ] Omega 3/fish oil
- [ ] B Complex/B12
- [ ] Coenzyme Q10
- [ ] Garlic
- [ ] Calcium
- [ ] Folic acid
- [ ] Biotin
- [ ] Other:

**Are you taking any birth control?** ◯ Yes ◯ No

If yes, please specify:

**Are you pregnant, trying to become pregnant, or just had a baby?** ◯ Yes ◯ No

**Are you menopausal and experiencing any issues?** ◯ Yes ◯ No

If yes, please elaborate:

**Are you undergoing hormone replacement therapy?** ◯ Yes ◯ No

If yes, please elaborate:

**Do you shave?** ◯ Yes ◯ No

If yes, what is your current preferred method of shaving:

**Are you experiencing any irritation from shaving?** ◯ Yes ◯ No

**Tick the boxes if you do any of the following (if yes, please state how often):**

- ☐ Smoke:
- ☐ Drink alcoholic beverages:
- ☐ Drink caffeinated beverages:

**Additional information**

| **Client's signature:** | **Date:** |
| --- | --- |