FACIAL CONSULTATION

DAWNING tranquility

Client Name: _____ DOB (mm/dd): _____

Address: _____ ☐ under 21 ☐ 21-30 ☐ 31-40

_____ ☐ 41-50 ☐ 51-60 ☐ 60+

Phone: _____ c h w Phone: _____ c h w Email: _____

Emergency Contact (Relationship) _____ Phone_____

How did you hear about us? _____

Your Health

Within the last year, have you been under a dermatologist or other physician's care? *Y N*

Within the last nine months, have you undergone any surgery? *Y N* If yes, to either, explain: _____

Have you experienced any illnesses or health problems in the past? *Y N* If yes, explain: _____

Do you have any known allergies? *Y N* If yes, specify: _____

Have you ever had a reaction to any of the following? ☐ cosmetics ☐ medicine ☐ iodine ☐ hydroxy acids
☐ animals ☐ fragrance ☐ food ☐ pollen
☐ sunscreens ☐ other: _____

List any medications, supplements, vitamins, diuretics etc. you take regularly (topical and/or oral) and the purpose:

_____

_____

Do you smoke? *Y N* Do you exercise regularly? *Y N* Do you follow a restricted diet? *Y N*

Do you wear contacts? *Y N* Do you have metal implants, a pacemaker or body piercings? *Y N*

Have you ever experienced claustrophobia? *Y N* What is your pain threshold? ☐ low ☐ medium ☐ high

Occupation: _____ Rate your level of stress on a scale of 1 to 5 *(1 = low stress, 5 = high stress)* _____

Your Skin

Ethnic Background: _____ Skin Type: ☐ Sensitive ☐ Dry ☐ Combination ☐ Oily

Do you have any special skin problems or specific concerns pertaining to your face or body?

If yes, specify: _____

What skin care products are you currently using?

Face: ☐ soap ☐ cleanser ☐ toner ☐ moisturizer ☐ masque ☐ exfoliator ☐ eye products

Body: ☐ soap ☐ shower gel ☐ scrubs ☐ oil ☐ body moisturizer ☐ depilatories ☐ self tanners

Skin Care Brands Currently Using: _____

Have you ever had Botox, Restylane or Collage injections? *Y N* Last injection? _____

Capillary Activity

Do you burn easily in moderate sunlight? *Y N*

Do you blush easily when nervous? *Y N*

Do you have a tendency to redness? *Y N*

Do you suffer from sinus problems? *Y N*

Exfoliation History

Have you ever had chemical peels, microdermabrasion, laser or other resurfacing service? *Y N* In the last month? *Y N*

Do you or have you ever used a prescription skin product, topical or oral, such as Accutane, Differin, Clindamycin or Obagi? *Y N* In the last month? *Y N* Name of product(s): _____

Are you currently using any OTC products with the following ingredients? *Y N*

☐ glycolic acid ☐ lactic acid ☐ any exfoliating scrubs ☐ any hydroxy acid products

☐ vitamin A derivatives (i.e. Retin-A, Renova, or Retinol) ☐ Clarisonic or another facial scrubber

Moisture Hydration

How much plain water do you consume daily? _____ How many alcoholic beverages do you consume weekly? _____

Do you ever experience these conditions on your skin: ☐ flakiness ☐ tightness ☐ obvious dryness

What SPF sunscreen do you use on your face? _____ body? _____ Do you sunbathe/use tanning beds? *Y N*

Oil Secretion

Do you ever experience oily shine during the day? *Y N* By: ☐ late morning ☐ mid-day ☐ evening

Do you ever experience skin breakouts? *Y N* If yes, explain: _____

Nerve Activity

Do you drink more than 4 caffeinated beverages (coffee, tea, soft drinks) daily? *Y N*

Do you ever experience a burning, itching sensation on your skin? *Y N*

Female Clients

Are you taking any oral contraceptions? *Y N*

Any recent changes to/from your contraceptive treatment? *Y N*

Are you pregnant or trying to become pregnant? *Y N*

Are you undergoing any hormone replacement therapy ? *Y N*

Are you lactating? *Y N*

Are you currently having/due for your menstrual cycle? *Y N*

Male Clients

What is your current shaving system? ☐ electric ☐ wet shave ☐ other _____

Do you experience irritation from shaving? *Y N*

Do you experience ingrown hairs? *Y N*

I understand, have read and completed this questionnaire truthfully and to the best of my knowledge. I agree that this constitutes as full disclosure and supersedes any previous verbal or written disclosures and precedes all future treatments . I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here at Dawning Tranquility are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____