

**SKIN ESSENTIALS, INC
THERAPEUTIC SKIN CARE CENTER**

Skin Treatment Assessment

Name _____ Date _____

Address _____

City _____ St _____ Zip _____ Date of Birth _____

Sex _____ Work Phone _____ Home Phone _____ Cell _____

Email address _____ Occupation _____

What radio station do you listen to? _____ What local TV station do you watch? _____

What newspaper do you read? _____ **Dermatologist Name** _____

Regular doctor Name & Phone # _____

How did you hear about Skin Essentials? _____

What do you feel is your skin type? Oily Combination Sensitive Dry Not sure

Do you have any food allergies? No Yes please list _____

Allergic to any medications? No Yes, please list _____

Have you had any sensitivities or reactions to skin care, make-up products, including sunscreen?

No Yes please list _____

Skin History

- | | | |
|---|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Acne | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Cold Sores | | |

Skin Conditions

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Acne Scarring | <input type="checkbox"/> Enlarged Pores |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Pigmentation | <input type="checkbox"/> Wrinkles |
| <input type="checkbox"/> Texture | <input type="checkbox"/> Uneven Tones | |

What do you want to accomplish from the treatments? _____

Please describe your skin care program or routine and brand

AM	PM

Do you take any other Medications? _____

Do you have any Metal plates or shunts? YES NO

Any other medical conditions we should be aware of? _____

How much water do you drink each day? _____

Do you drink: coffee? how much? _____ Soda _____ Tea _____

	YES	NO
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Are you having an increase of stress now?	<input type="checkbox"/>	<input type="checkbox"/>
Do you sunburn easy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you daily sun protection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you have prior chemical peels?	<input type="checkbox"/>	<input type="checkbox"/>
Facial Surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Botox?	<input type="checkbox"/>	<input type="checkbox"/>
Collagen Injections	<input type="checkbox"/>	<input type="checkbox"/>
Do Wear Contacts?	<input type="checkbox"/>	<input type="checkbox"/>
Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you claustrophobic?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear any medicated patches?	<input type="checkbox"/>	<input type="checkbox"/>
Do wear any electronic devices?	<input type="checkbox"/>	<input type="checkbox"/>
Are you receiving chemotherapy treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Are you receiving radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>

Do You Have A Personal History Of:

Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> regulated? _____
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>

<u>Are You Currently Taking Or Using:</u>	Yes	No
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Accutane	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>
Steroid Creams	<input type="checkbox"/>	<input type="checkbox"/>
Hormones	<input type="checkbox"/>	<input type="checkbox"/>
Retin-A, Renova	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin A, Afirm	<input type="checkbox"/>	<input type="checkbox"/>
Exfoliating Cleanser	<input type="checkbox"/>	<input type="checkbox"/>
Glycolic Acid	<input type="checkbox"/>	<input type="checkbox"/>

I understand that the services offered are not a substitute for medical care, and any information provided by the therapist is for educational purposes only and not for diagnostically prescriptive in nature. I understand that the information herein is to aid the therapist in giving better service and is completely confidential. By signing this release, I hereby waive and release Skin Essentials, and any therapists work with Skin Essentials, Inc, from any and all liability, past, present, and future, relating to Skin treatments.

Skin Essentials is not responsible for reactions caused by the guest and for reactions caused as a result of the information above not being correct or complete. I understand that this information will be used only by the providers of Skin Essentials and will be held in confidence; information will not be released to anyone without my written consent.

Signed _____ Date _____
 (Parent or guardian if under 18 years of age)

Skin Essentials Client Responsibilities

- Arrive 10-15 minutes before your scheduled time. _____ *initials*
- Schedule next visit prior to leaving to ensure your preferred date and time. _____ *initials*
- Cancel appointments 24 hours in advance. _____ *initials*
- 50% charge for cancellations less than 24 hours. _____ *initials*
- 100% charge for not showing for you appointment. If you are using a gift certificate it will be voided. _____ *initials*
- **Silence cell phones & pagers.** _____ *initials*
- To follow recommended skin program for optimal results. _____ *initials*
- No children, unless they being treated. _____ *initials*