CONFIDENTIAL HEALTH INTAKE

1. What is the reason for your visit today?

2. What special areas of concern do you have?

❑ Acne scarring ❑ Pigmentation ❑ Age spots
❑ Fine lines & wrinkles ❑ Sun damage ❑ Scars
❑ Hair removal ❑ Stretch marks ❑ Acne

3. Do you? ❑ Sun bathe ❑ Use a tanning bed
How often?: _____

4. Have you ever had?:
❑ Microdermabrasion ❑ Cosmetic surgery
❑ Laser hair removal ❑ Cosmetic fillers
❑ Restylane® ❑ Collagen Injections
❑ Botox® ❑ Chemical or natural peels
❑ Body treatments

Response: _____

5. Do you bruise easily?: ❑ Yes ❑ No

6. Do you get cold sore/blisters?
(Herpes zoster/shingles) ❑ Yes ❑ No

7. What medications/hormone replacements/vitamins do you take?

8. Have you ever used: ❑ Accutane® ❑ Retin-A®
❑ Renova® ❑ Topical Antibiotic ❑ Hydroquinone

9. Personal or family history of cancer?: ❑ Yes ❑ No

10. Are you under the care of a physician?: ❑ Yes ❑ No

If yes, explain: _____

11. Have you had Botox® or any other filler?: ❑ Yes ❑ No

12. Have you ever had a reaction to?:
❑ Metals ❑ Medication ❑ Food ❑ Cosmetics
❑ Fragrance ❑ Airborne Particles
❑ Other allercies (milk, apples, citrus, grapes, aloe vera, aspirin)

13. Do you wear contact lenses?: ❑ Yes ❑ No

14. FOR MEN
Do you experience breakouts? ❑ Yes ❑ No
Do you have ingrown hair? ❑ Yes ❑ No

15. FOR WOMEN
Are you on birth control? ❑ Yes ❑ No
Do you take hormone replacement? ❑ Yes ❑ No
Are you pregnant? ❑ Yes ❑ No

16. How would you describe your overall health?
❑ Excellent ❑ Good ❑ Fair ❑ Poor

17. Have you had any of the following, past or present?

Acne	❑ Yes	❑ No
If yes, when: _____		
Allergies	❑ Yes	❑ No
Arthritis or Bursitis	❑ Yes	❑ No
Irregular Blood Pressure	❑ Yes	❑ No
Breast Implants	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
If yes, what: _____		
Cataracts	❑ Yes	❑ No
High Cholesterol	❑ Yes	❑ No
Claustrophobia	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Diarrhea/Constipation	❑ Yes	❑ No
Exzema	❑ Yes	❑ No
If yes, where: _____		
Epilepsy	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
How often:	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No
If yes, what: _____		
Hepatitis	❑ Yes	❑ No
Hirsutism	❑ Yes	❑ No
HIV	❑ Yes	❑ No
Hormone Imbalance	❑ Yes	❑ No
Infections	❑ Yes	❑ No
Lupus	❑ Yes	❑ No
Metal Implants	❑ Yes	❑ No
Pace Maker	❑ Yes	❑ No
Phlebitis	❑ Yes	❑ No
Psorias or Vitiligo	❑ Yes	❑ No
Serious Injury	❑ Yes	❑ No
If yes, what: _____		
Thyroid	❑ Yes	❑ No
Varicose Veins	❑ Yes	❑ No

Lifestyle and Diet

18. Do you normally sleep well? ❑ Yes ❑ No
19. Do you smoke? ❑ Yes ❑ No
20. Do you regularly exercise? ❑ Yes ❑ No
21. Do you have food intolerances? ❑ Yes ❑ No
If yes, explain: _____

22. Do you follow any special diet? ❑ Yes ❑ No
If yes, explain: _____

23. What is your stress level? ❑ High ❑ Medium ❑ Low
24. Daily water intake: _____ glasses a day
25. How many cups of caffeine-type beverages
(coffee, tea, soft drinks) do you consume daily?
❑ None ❑ 1-3 cups ❑ 4 or more

CONFIDENTIAL HEALTH INTAKE

26. What do you consume on a daily basis? ❑ Fruit ❑ Protein ❑ Complex Carbohydrates ❑ Vegetables & Salad

27. How would you rate your skin? Select one.
- ❑ Always burns, never tans.
- ❑ Burns easily, tans slightly.
- ❑ Burns moderately, tans gradually.
- ❑ Seldom burns, always tans well.
- ❑ Rarely burns, deep tan.
- ❑ Never burns, deeply pigmented.

28. Ethnic background:
- ❑ English/Irish ❑ Italian/Mediterranean
- ❑ Native American ❑ Asian
- ❑ African American ❑ Russian
- ❑ German/Dutch ❑ Polish/Hungarian
- ❑ Hispanic ❑ Other _____

29. How would you describe your skin?
Circle all that apply:
Normal Oily Dry T-zone/Combination Freckled
Sun-Damaged Uneven Blotchy Mature Wrinkled Saggy
Firm Large Pores Small Pores Acne Milia Comedones
Occasional Breakouts Scarred Cystic Melasma Florid
Rosacea Asphyxiated Sallow Perfumed-Stained
Hypopigmented Post-Inflammatory Hyperpigmented

30. Eye Color:
Blue Green Hazel Gray Light Brown Dark Brown

31. Natural Hair Color:
Blonde Red Light Brown Medium Brown Dark Brown
Blank Gray/Silver White

32. Skin Tone:
Pale/White Light Reddish/Freckles Light Olive Medium Olive
Dark Olive Brown Black

Commitment

33. How committed are you to achieving results?
❑ Not sure ❑ Mildly committed ❑ Very committed

34. We will discuss certain recommendations to assure the success in your treatment program such as daily water intake and/or home care regimen. During the course of your treatment, it may be necessary to recommend adjustments to your program.
Would that be okay with you?
❑ Yes ❑ No

Your practitioner will recommend the appropriate schedule for future treatments in order to achieve your goals.

Informed Release

I _____, do fully understand all the questions above and have answered them correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the practitioner will completely inform em of what to expect in the course of treatment, and will recommend adjustments to my regimen if deemed necessary.

I have completely discussed my concerns and have had my questions answered. I also am aware that individual results are dependent upon my age, health condition, and lifestyle. I agree to actively participate in following appointments schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment of suggested home care routine, I will inform my practitioner immediately.

I release the therapist, Karen Hawkins and the staff harmless from any liability that may result from this treatment.

Signature _____ Date _____

Consultation Notes: