DATE	SERVICE - TREATMENT	$Fee	Retail	Remarks / Therapist

PH-26

PROFESSIONAL SERIES

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NEW IMPROVED!

Skin Care Client Profile & History ™ 2007

In order to provide you with the best possible services.....please complete the following:

Name_____Date_____
Bus: Ph. _____Res: _____Cell:_____
Address: _____
City _____State_____ZIP_____
Birth Date: Month_____/_____ ☐ Client Photo ☐1st Visit_____/_____
MEDICAL: Are you currently or within the last year under
ANY Doctors care? ☐ NO ☐ YES? Explain: _____
Health Problems: Diabetes, Thyroid, Heart, Cancer, Hysterectomy,
Hormone imbalance, Epilepsy, Diet, Drugs & Vitamins, Other_____
☐ **Medical or Skin Conditions** ☐ **Bleeding Disorders** ☐ **Medications**
☐ **Allergies to Topical Solutions** ☐ **Medicines** ☐ **Health Problems**
☐ **Complications at a Service**_____
☐ Retin-A ☐ Accutane ☐ Diet Tablets ☐ Smoke ☐ Stimulants
☐ Oral Contraceptives ☐ Laxatives ☐ Diuretics ☐ Other:_____
Have you undergone any surgery? ☐ NO ☐ YES? X-Rays ☐ NO ☐ YES?
Do you have any implants? ☐ Metal ☐ Other Explain: _____
Computer_____Hrs./Day_____eMail/Web_____
How many hours a day do you Work?_____Other?_____Total_____
Do you sleep and exercise regularly? ☐ NO ☐ YES? Explain: _____
REMARKS _____
_____

Therapist_____Lic.#_____
What is your daily consumption of: Water_____Oz. Coffee_____Oz. _____
Tea_____Oz. Soft Drinks (Diet/Reg)_____Oz. Other_____
What water temperature do you cleanse with? ☐ Cold ☐ Warm ☐ Hot
Skin Condition? ☐ Dry ☐ Oily ☐ Unremarkable._____
Any special skin problems? ☐ Flaking ☐ Tightness ☐ Other_____
Have you ever had a reaction to any treatments? ☐ NO ☐ YES?_____
Do you ever experience any skin break out? ☐ NO ☐ YES?_____
Does PABA affect you in any way? ☐ NO ☐ YES?_____
Personal skin care now? ☐ Soap ☐ Cleanser ☐ Toner ☐ Scrub
☐ Masque ☐ Moisturizer ☐ Other:_____
Do you? Blush easily ☐ NO ☐ YES? Sunburn ☐ NO ☐ YES? SPF#_____
Redness Tendency ☐ NO ☐ YES? Massage Preference? ☐ Firm ☐ Light
Sinus Problems? ☐ NO ☐ YES? Pain Threshold ☐ Low ☐ Medium ☐ High?
Do you have reactions to: ☐ Cosmetics ☐ Metals ☐ Pollen ☐ Foods ☐ Animals
FEMALE CLIENTS ONLY: Are you pregnant or trying to be? ☐ NO ☐ YES?
Are you taking oral contraception? ☐ NO ☐ YES?_____
Are you due for your menstrual period within the next week? ☐ NO ☐ YES?
Who was your last skin therapist?_____
Who Referred you?_____
Stylist_____Nail Tech_____

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