

Skin Care Consultation Form

Client Information			
First Name	Last Name	Preferred Name	Patient ID
Gender	Preferred Pronouns	Date of Birth	Marital Status
Address		City	State
Email		Preferred Phone Number	
Emergency Contact			
Full Name	Relationship	Contact Number	
Full Name	Relationship	Contact Number	
Insurance Information (If Applicable)			
Insurance Carrier	Insurance Plan	Contact Number	
Policy Number	Group Number	Social Security Number	
Skin Care			
What are your skin care concerns? ☐ Wrinkles/Fine Lines ☐ Hyperpigmentation/Sun Damage ☐ Acne/Acne Scarring ☐ Redness/Rosacea ☐ Aging ☐ Melasma ☐ Sensitivity ☐ Other:			
Current skin condition diagnosis (if applicable)			
Have you had skin care treatments before?			
What skin care products do you currently use? ☐ Cleanser/Face Wash ☐ Bar Soap ☐ Face Scrub/Exfoliants ☐ Toner ☐ Serums ☐ Moisturizer ☐ Sunscreen ☐ Eye Product(s) ☐ Lip Product(s) Please list the product names:			
Have you received hair removal services? If so, please describe			

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Skin Care (Continued)			
Have you received chemical peels, lasers, or microdermabrasion treatments? If so, please describe			
Have you received any Botox, Juvederm, or dermal fillers? If so, please describe			
Do you wear...			
Contact Lenses	☐ Yes ☐ No	Body Piercings	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No
Do you take any of the following supplements?			
☐ Multivitamin	☐ Zinc	☐ Garlic	
☐ Vitamin C	☐ Omega 3/Fish Oil	☐ Calcium	
☐ Vitamin D/D3	☐ B Complex/B12	☐ Folic Acid	
☐ Melatonin	☐ Coenzyme Q10	☐ Biotin	
☐ Other:			
On a scale of 1(best) to 5(worst), what is your current stress level?			
☐ 1	☐ 2	☐ 3	☐ 4 ☐ 5
Do you drink any caffeinated beverages? ☐ Yes ☐ No			
Are you taking any birth control? If so, please specify			
Do you shave? ☐ Yes ☐ No			
Are you experiencing irritations? ☐ Yes ☐ No			
Please list any current medications			
Please list any current medical diagnosis			
Please list any current allergies			
Signature of Client		Date	