CLIENT PROFILE CARD

Today's Date: ____________________Date of Birth _____/_______/____________
Name:____ Occupation:____________________________
Address:____
City/State/Zip:____
Email:____
Bus Ph: (   ) __________________________ Res Ph: (   ) ____________________________________
Cell Ph: (   )_________________________________
Emergency Contact:____Phone _________________________
Referred by:____________________________________ Have you ever had a massage? Yes___ No___
Facial? Yes___No___ PhotoRejuvenation? Yes___No___ Microdermabrasion? Yes___No_______
What is your specific concern about your skin?____
How long have you noticed your condition?____

Medical: Are you currently or within the last year under any Doctor's care? Yes____ No _________
Explain: ____

Circle any Health Problems: Diabetes, Thyroid, Heart, Cancer, High or Low Blood Pressure, HIV/Aids, Epilepsy, Arthritis, Tendenitis, Bursitis, Nail or Foot Fungus, Urinary or Kidney Problems, Varicose Veins, Hepatis A, B, or C, Circulatory Problems, Depression, Lupus, Pacemaker, Psoriasis, Scleroderma, Fever Blisters, Eczema, Stroke, Sunburn, Anemia, Fibromyalgia, Stress related illness, Scoliosis, Chemotherapy, Radiation, Skin Disease, Hormone Problems, Cold hands or feet, Contact Lens, Blood Disorder, Blood Thinner, Artificial Implants, Phlebitis, Hyper/Hypo Pigmentation, Claustrophobia, Sinus, Headaches, Contagious Diseases, Joint Swelling, Skin Cancer, Hysterectomy, Alcoholism, Whiplash, Other____

Are/have you using/taking: Antibiotics, Accutane, Retin A, Glycolic or Alphahydroxy acids, Azelex, Differin, Tazarac, Tanning Bed, Diet Tablets, Smoke, Stimulants, Oral Contraceptives, Laxatives, Diuretics, Other ________________________________If so, How long?___________________
Medications, & Vitamins – List all and why: ____
____
If you have known allergies, please list them:____
Are you allergic to any beauty products that you know of? Yes___ No ___, If so, please let us know what they are ____
Are you allergic to: Aspirin, Glycolic, Any plants, botanicals, Nuts. If yes, please provide their names: ____

Have you undergone surgery recently? Yes____ No____Explain__________________________________
__________________________________Any Numbness/Stabbing pain anywhere: __________________
Have you had recent plastic surgery? Yes ____ No ____Explain ________________________________
If you recently had surgery, do you have permission from your doctor for a facial ? _______________
Do you have any metal implants/pacemaker? Yes _____ No ____ Explain
____

Do you exercise regularly? No ____ Yes ______ Explain ______________________________________
What is your daily consumption of : Water _______oz. Coffee _____ oz. Tea _____ oz. Other ___ oz. Soft Drinks (Diet/Reg.)______ oz.

Do you have LASH EXTENSIONS? NO_______ YES__________

FEMALE CLIENTS ONLY: Are you trying to become pregnant? Yes ____ No _____

Do you ever experience skin break-outs? Regularly ( ) Occasionally ( ) Never ( )
What type skin do you believe you have? Normal ( ) Dry ( ) Oily ( ) Combination ( )
Do you have redness in your cheeks? Yes ______ No ___Sunburn easy? Yes ____ No ______
Do you have comedones (blackheads)? Yes _____ No _____Milia (whiteheads)? Yes____ No ____

Brand of Personal skin care products: Soap ____________ Cleanser ________________________
Toner __________________Scrub __________________ Masque ____________________________
Moisturizer _____________________Sunscreen SPF # _____________________________________
Other____

I am responsible for any valuable items I bring into the treatment room with me.

Client Signature ____Date ____________________