The Skincare Studio by Claudia Duran

Client Profile

Please fill in the fields below.

Today's Date: ____________________________________

Name: ____

Date of Birth: _________________________

Address: ____

Home Phone: _____________________
Work Phone: ________________________
Cell Phone: ___________________________
eMail Address: ____
____

Employer: _______________________________________
Occupation: ____

How did you learn about us?

Your Skin Care

What areas of special concern do you have regarding today's treatment? (Please Circle any that apply and explain)

FACE: Breakouts/acne, Blackheads/whiteheads, Excessive oil/shine, Rosacea, Broken capillaries Redness, Sun spot/liver spot/brown spot, Uneven skin tone, Sun damage, Wrinkles/fine lines, Dull/dry skin, Flaky skin, Dehydrated Other ____________________________

Eyes: Dehydrated , wrinkles , puffiness , dark circles. Other: _______________

Tell me about your diet and your water intake? How much do you drink in a day? Be honest!

On a scale of 1-10, how would you rate your current stress

level? And is this a spike or a continuous thing? (low) 1 2 3 4 5

6 7 8 9 10 (high)

Have you ever had a skincare treatment before? No /Yes,

How recently?

What did you like about it or not like?__________________

Have you ever had chemical peels, laser or microdermabrasion? No /Yes In the last month? No / Yes How do they work for you?

Have you used Glycolic Acid, Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products in the past week? No / Yes describe:

Have you used an acne medication? No / Yes, When? Which drug? Or which Over the Counter product?____________________

What skin care products are you currently using? (List brand where known) and how often do you apply them?

Have you used any of the following hair removal methods in the past week? No/ Yes, circle all that apply.

Shaving, Waxing, Laser Hair Removal, Tweezing, Threading, Depilatories

Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain) If yes, please explain: ____

Cosmetics
Medicine
Food Latex
Animals
Fragrance
Sunscreens
Iodine
Pollen

Other ____________________________________

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume a day? ________

Do you smoke? Yes No

Have you experienced Botox, Restylane or Collagen injections in the past 2 weeks? No /Yes

specify:____

Female Clients Only:

Are you taking oral contraceptives? No/Yes
specify:____

Any recent changes to or from your contraceptive treatment? No / Yes
If so, what and when: ____

Are you pregnant or trying to become pregnant? No /Yes

Are you lactating? No/Yes

Any menopause problems? No /Yes____

Are you undergoing any hormone replacement therapy? No/ Yes

specify:____

Male Clients Only:

What is your current shaving system? Wet shave or
Electric Do you experience irritation from shaving? No /
Yes

Ingrown hairs a problem? No/ Yes____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature:
____

Date:_______/______/________________