SKIN INFORMATION:

Do you wear **CONTACT LENSES?** _____yes _____no

Have you ever seen a dermatologist for your skin? _____yes _____no If yes, Explain_____

_____

Have you ever had an adverse reaction after using a skin care regimen? _____yes _____no

If yes, describe (rash, irritation, peeling, sensitivity, etc.) _____

Have you ever had a *skin allergy?* Cosmetics _____yes _____no Fabrics _____yes _____no

Fragrance _____yes _____no Rashes _____yes _____no Other_____ if yes, to any, please explain _____

Pigmentation: Even Uneven Birthmark Pregnancy Mask

Does your skin appear fragile or burn easily? _____yes _____no

Have you or any member of your family had skin cancer _____yes _____no

If *yes,* please explain _____

What is your ethic background? _____

Do you form thick or raised scarring from a cut or burn _____yes _____no

Broke Capillaries: Nose Cheek Chin Forehead Face

Is your skin: Dry Combination Oily Acne Prone

Do you have a history of acne or periodic breakouts? _____yes _____no

Do you have Exessive Oil Acne Scars Hormone related acne If yes, how frequent?_____

Does your skin flake or fell tight and dry? _____yes _____no _____sometimes

Is your skin shiny a few hours after cleansing? _____yes _____no _____sometimes

Do you use wax or use depilatories on your face? _____yes _____no If yes, Explain_____

Have you ever had a fever blister? _____yes _____no If yes, how frequent? _____

Have you had any active fever blister in the last 4-6 weeks? _____yes _____no

Have you ever had *facial surgery, facial peels, laser surgery or dermabrasion*? _____yes _____no

If yes, Explain_____

Client Signature_____Date_____/_____/_____

Therapist Signature_____Date_____/_____/_____