SAVING FACES

ACNE AND SKINCARE CLINIC

COMMITTED TO MAKING A DIFFERENCE

CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

(Please Print) Today's Date:_____

First Name_____ Last Name _____ Date of Birth ____/____/____

Street_____ Apt #_____ City _____ State _____ Zip _____

Phone – Home (_____) _____Work (_____)_____ Mobile (_____)_____

Dermatologist / Physician _____ Phone (_____)_____

Emergency Contact_____ Phone (_____) _____

Your Occupation _____ Email_____

Referred By: [ ] Friend [ ] Mailer [ ] Walk-By [ ] Yellow Pages
[ ] Gift Certificate [ ] Other _____

Aesthetician's Name _____

1. What is the reason for your visit today? _____
2. What special areas of concern do you have? _____

EXPECTATIONS & HISTORY

3. Which conditions would you like to improve?

[ ] Acne scarring	[ ] Hyperpigmentation
[ ] Acne	[ ] Broken Capillaries
[ ] Age Spots	[ ] Stretch Marks
[ ] Enlarged Pores	[ ] Surgical/Facial scars
[ ] Fine line & Wrinkles	[ ] Other _____

4. Have you ever had facial treatment in the past? [ ] Yes [ ] No
5. What was your experience? _____
6. How would you describe your skin?

[ ] Normal [ ] Dry [ ] Oily
[ ] Combination [ ] Sensitive [ ] Sun Damaged

7. How would you rate your skin?

I Always Burn
II Burns easily, tans slightly
III Burns moderately – tans gradually
IV Seldom Burns – Always tans well
V Rarely burns - Deep tan
VI Never burns – Deeply pigmented

8. Do you experience: [ ] Flakiness? [ ] Tightness?
[ ] Redness? [ ] Excessive oily shine during day?

9. What is your present skin regimen?
   [ ] Soap & water only [ ] Cleanser [ ] Toner [ ] Mask
   [ ] Moisturizer [ ] Exfoliation [ ] Sun block every day
   [ ] Other _____

10. Are you ever exposed to chemicals, oils, or other caustic substances that may aggravate your skin?
    [ ] Yes [ ] No

    If yes, what are they? _____

11. Do you blush easily? [ ] Yes [ ] No

    If yes, what are the contributing factors? [ ] Emotions [ ] Foods
    [ ] Temperature Changes [ ] Other _____

12. Do you: [ ] Sun bathe? [ ] Use a tanning bed? How often? _____

13. Have you ever had:
    [ ] Peels [ ] Botox
    [ ] Microdermabrasion [ ] Laser Resurfacing
    [ ] Facial Surgery [ ] Collagen Injections
    [ ] Cosmetic Surgery

    How Recently? _____

14. Are you under treatment for any current skin condition? [ ] Yes [ ] No

    If yes, what? _____

15. Does your skin heal: [ ] Fast [ ] Scars [ ] Pigments

16. Do you bruise easily? [ ] Yes [ ] No

17. Do you get sores/blisters (Herpes Zoster/Shingles) [ ] Yes [ ] No

18. What medications/hormone replacement/vitamins do you presently take?

    _____

19. Have you ever used: [ ] Accutane [ ] Retin-A [ ] Renova [ ] Topical Antibiotics
    [ ] Differin [ ] Tazarac [ ] Alpha Hydroxy Acids [ ] Hydroquinone

    If yes, when and how long? _____

20. Any personal or family history of skin cancer? [ ] Yes [ ] No

    Provide detail _____

21. How would you describe your overall health: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

22. Have you had any of the following, past or present?

Acne	[ ] Yes	[ ] No	When _____
Allergies	[ ] Yes	[ ] No	
Arthritis or Bursitis	[ ] Yes	[ ] No	
Blood Pressure	[ ] High	[ ] Low	[ ] Normal
Breast Implants	[ ] Yes	[ ] No	
Cancer	[ ] Yes	[ ] No	
Cataracts	[ ] Yes	[ ] No	
Cholestorol	[ ] High	[ ] Low	[ ] Normal
Claustrophobic	[ ] Yes	[ ] No	
Diabetes	[ ] Yes	[ ] No	
Diarrhea/constipation	[ ] Yes	[ ] No	
Eczema	[ ] Yes	[ ] No	Where _____
Epilepsy	[ ] Yes	[ ] No	
Hay Fever	[ ] Yes	[ ] No	
Headaches	[ ] Yes	[ ] No	How Often _____
Heart disease/conditions	[ ] Yes	[ ] No	What _____
Hepatitis	[ ] Yes	[ ] No	
HIV/AIDS	[ ] Yes	[ ] No	
Infections	[ ] Yes	[ ] No	
Menopausal	[ ] Yes	[ ] No	
Metal Implants	[ ] Yes	[ ] No	
Pace Maker	[ ] Yes	[ ] No	
Phlebitis	[ ] Yes	[ ] No	
Serious Injury	[ ] Yes	[ ] No	What _____
Sleep problems	[ ] Yes	[ ] No	
Thyroid	[ ] High	[ ] Low	[ ] Normal
Varicose veins	[ ] Yes	[ ] No	
Do you smoke?	[ ] Yes	[ ] No	

Do you wear contact lenses? [ ] Yes [ ] No

23. Have you ever had a reaction to: [ ] Cosmetics [ ] Metals [ ] Medication
[ ] Food [ ] Fragrance [ ] Airborne Particles
[ ] Other _____

24. FOR WOMEN:

Oral contraceptives?	[ ] Yes	[ ] No
Are you pregnant or trying to get pregnant?	[ ] Yes	[ ] No
Are you taking hormone replacement?	[ ] Yes	[ ] No
Do you experience hormone imbalances?	[ ] Yes	[ ] No

25. FOR MEN:

Do you shave with	[ ] Electric Shaver	[ ] Razor
Do you experience skin breakouts?	[ ] Yes	[ ] No
Do you have ingrown hair?	[ ] Yes	[ ] No

LIFESTYLE & DIET

1. Is your stress level [ ] High [ ] Medium [ ] Low
2. Do you normally sleep well? [ ] Yes [ ] No
3. Do you regularly exercise? [ ] Yes [ ] No
4. Do you have food intolerances? [ ] Yes [ ] No What?_____
5. Do you follow any special diet? [ ] Yes [ ] No

6. How many glasses of water do you consume daily? _____

7. How many cups of caffeinated beverages (coffee, tea, soft drinks) do you consume?
   [ ] 1-3 cups [ ] 4 or more

8. In our treatment program, it may be necessary to recommend alterations to or additions in your home care regimen; would that be okay with you? [ ] Yes [ ] No

Your practitioner will recommend the appropriate schedule for future facial treatments or physician referral order to achieve your skin improvement goals.

INFORMED CONSENT RELEASE

I_____, do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the aesthetician will completely inform me of what to expect in the course of treatment and will recommend adjustments to my regimen if deemed necessary. I also am aware that individual results are dependant upon my age, skin condition and lifestyle. I agree to actively participate in following appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum effectiveness. In the event that I may have additional questions or concerns regarding my treatment or suggested home product routine, I will consult with my aesthetician immediately.

I release and hold harmless the aesthetician, Cyndi Jarvis Saving Faces Acne and Skincare Clinic, and the staff from any liability for adverse reactions that may result from this treatment.

POLICIES

1. We require 48-hours notice for cancellations. Cancellation for Monday must be phoned in on the Friday before.
2. if you are not satisfied with your service or products, please contact your skin specialist within 24 hours after your appointment so that the situation may be corrected. It is our policy to provide you with the best professional service and products customized for your skin condition.

I have read and understood all of the foregoing information

_____ _____

Client Signature Date

"Confidential Skin Health Questionnaire" from P. Pugliese. Advanced Profesional Skin Care: Medical Edition. The Topical Agent, LLC, 2005.

Please return completed questionnaire to:

Saving Faces Acne & Skincare Clinic
2 1/2 Beacon Street, 2nd Floor
Concord, NH 03301

603-397-2384
ww.SavingFacesAcne.com