# Client Questionnaire

## YOUR INFORMATION

Name _____ Age _____ DOB _____ Ethnicity _____
Address _____ City _____ State _____
Zip _____ Cell Phone _____ Other Phone _____
Email _____

Please indicate if you have used any of the medications or drugs listed below in the last 2 years, when they were used, and for how long you used them.

| MEDICATION | WHEN | HOW LONG | MEDICATION | WHEN | HOW LONG |
|---|---|---|---|---|---|
| Antibiotics (oral) | | | | | |
| Antibiotics (topical) | | | | | |
| Accutane | | | | | |
| Benzoyl Peroxide | | | | | |
| Retin-A, Tazorac, Differin | | | | | |
| Thyroid medication | | | | | |
| Blood Thinning Meds | | | | | |

Please list any other medications or drugs listed that you have used in the past 2 years and include when they were used, and for how long you used them: _____

## MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

| | | | | | |
|---|---|---|---|---|---|
| Herpes Simplex | ☐ | HIV/AIDS | ☐ | Hemophilia | ☐ |
| Eczema | ☐ | Thyroid Problems | ☐ | Lupus | ☐ |
| Psoriasis | ☐ | Hormone Prolems | ☐ | Anemia | ☐ |
| Hepatitis | ☐ | Hysterectomy | ☐ | High Blood Pressure | ☐ |
| Cancer | ☐ | Ovary(ies) Removed | ☐ | Diabetes | ☐ |
| Staph Infection/MRSA | ☐ | Pacemaker | ☐ | Metal Pins in Body | ☐ |

## YOUR PRIMARY CARE PHYSICIAN:

Name: _____ Phone: _____

Are you under a dermatologist's or other physician's care? Yes ☐ No ☐

If yes, doctor's name: _____

## LIFESTYLE CONSIDERATIONS

Have you ever had any reaction to any products or anything you have put on your face? Yes ☐ No ☐
If yes, what products? _____

Please check any of these you are allergic to: Sulfur ☐ Aspirin ☐ Latex ☐
List any other allergies you know of:
_____

Do you smoke/vape? Yes ☐ No ☐ If yes, what do you smoke _____

Do you use fabric softener or fabric softener sheets in the dryer? Yes ☐ No ☐

Do you swim in a chlorinated pool? Yes ☐ No ☐

Do you work around chemicals, tars, oils, grease or inks? Yes ☐ No ☐

Occupation: _____ Do you work nights? Yes ☐ No ☐

Are you currently under a lot of stress? Yes ☐ No ☐ (common stress triggers: job loss, new job, wedding, death in the family or close friend, graduation, long commute, heavily scheduled)

Do you use birth control pills, shots or use an IUD? Yes ☐ No ☐
If so, which do you use? _____ What brand of pill?
_____

Are you pregnant or nursing? Yes ☐ No ☐

Do you have shaving irritation on your face? Yes ☐ No ☐
What type of razor do you use for shaving (i.e, double blade, triple blade, rotary)
_____

## DIET - DO YOU CONSUME THE FOLLOWING?

| FOODS | | HOW OFTEN PER WEEK | FOODS | | HOW OFTEN PER WEEK |
|---|---|---|---|---|---|
| Fast Food | ☐ | | Peanuts | ☐ | |
| Processed Food | ☐ | | Sushi | ☐ | |
| Salty Snacks | ☐ | | Kelp and Seaweed | ☐ | |
| Milk/Yogurt | ☐ | | Miso Soup | ☐ | |
| Cheese | ☐ | | Soy | ☐ | |
| Whey or Soy Protein | ☐ | | Vitamins/ Supplements | ☐ | |
| Peanut Butter | ☐ | | Seafood | ☐ | |

Have you ever used any Face Reality Skincare products? Yes ☐ No ☐

If yes, please list the products:

_____

Are you still currently using Face Reality Skincare products? Yes ☐ No ☐

**PRODUCTS CURRENTLY USING - PLEASE PROVIDE PRODUCT NAMES**

| | |
|---|---|
| **CLEANSER** | |
| **TONER** | |
| **SERUMS** | |
| **MOISTURIZERS** | |
| **SUNSCREEN** | |
| **MASK** | |
| **FOUNDATION** | |
| **BLUSH** | |
| **EXFOLIANT (ACIDS, SERUMS, SCRUBS)** | |
| **ACNE MEDICATIONS** | |
| **ANYTHING ELSE?** | |

**OTHER TREATMENTS: WHAT ELSE HAVE YOU DONE FOR YOUR SKIN IN THE LAST 90 DAYS?**

| TREATMENT | WHEN? | WHERE? |
|---|---|---|
| Chemical Peels | | |
| If so, what kind: | | |
| Microdermabrasion | | |
| Dermabrasion | | |
| Laser Hair Removal | | |
| Laser Rejuvenation/Resurfacing | | |
| Skin Cancer Removal | | |
| Facial Waxing | | |
| Electrolysis | | |
| Other: | | |

How did you hear about us?: _____

# Acne Treatment Consent Form

An acne treatment may consist of surface cleansing, mild chemical peels or steam and exfoliation, application of antibacterial serums, corrective serums, and extractions. Treatments take approximately **20 to 45 minutes** to complete and are designed to balance, hydrate, extract acne impactions, and prepare the skin for the home care routine. Implements and equipment used in this facility are disposable or properly sterilized according to the State Board of Cosmetology regulations.

IMPORTANT: Please Read Carefully and Initial

_____ I have not been exposed to excessive sun and my skin does not feel sensitive or irritated in any way.

_____ I have not had any other chemical peel of any kind , within **14 days** of this treatment.

_____ I have not had any facial waxing, within **7 days** of this treatment.

_____ I have informed the clinic of all health problems of which I am aware, including herpes simplex/cold sores.

_____ I have informed the clinic of any use of oral or topical medications I may be using including any retinoids (Retin-A, Renova, Avita, Differin, Tazorac) or Accutane (Isotretinoin).

_____ I understand that clear the skin of acne is best achieved through a series of treatments and consistency with the homecare product routine recommended by my Acne Expert.

_____ I understand that I will probably not experience much visible peeling, flaking, discoloration or irritation following this procedure if I follow my home care instructions carefully.

WARNINGS: Please Read Carefully and Initial

_____ Avoid direct sunlight or tanning booths for at least 3 days following a treatment.

_____ Use of sunblock protection is necessary following all treatments.

_____ Do not pick your skin following a treatment.

_____ Face Reality Skincare products are clinical-strength active formulas. Mild tingling sensations are possible with product application but should not be irritating. If you are experiencing stinging and or irritation with any product, stop using the product and contact your Acne Expert for guidance.

RESCHEDULING GUIDELINES AND LATE POLICY: Please Read Carefully and Initial

_____ A **24-hour** rescheduling notice is required. We realize emergencies will happen and will be considered, but we reserve the right to charge a **$50** fee for missed appointments without **24-hour** notice. If you are more than **20 minutes** late, we cannot guarantee that we will be able to fit your appointment into the schedule and you may not be seen. If we cannot fit you into the schedule, there will be a **$50** fee charged for the missed appointment.

I, _____ , consent to photographs taken of my face to be used for monitoring treatment progress.

I hereby agree to all of the above and agree to have this treatment performed on my skin. I further agree to follow all post-treatment care instructions as I am directed.

Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zipcode: _____

Signature of Client: _____

Signature of Esthetician: _____