SKIN REVISION AZ
Studio Aesthetique

Confidential Client Health History Form

Date: _____

Name: _____ Date of Birth: _____
Address: _____
Home Phone:_____ Business Phone: _____
Cell Phone: _____E-mail: _____
Physician: _____Phone: _____
Emergency Contact: _____ Phone: _____
Occupation: _____ Does your job require that you work outdoors? No Yes

Referred by:_____

Your Health:

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?
No Yes, explain:
_____

2) Any recent surgery, including plastic surgery? No Yes, explain: _____
_____

3) Any skin cancer? No Yes, explain: _____

4) Have you had any piercings, tattoos, or permanent cosmetics? No Yes, If yes, where on your person?
_____

5) Have you had any of these health conditions in the past or present? (Please circle any that apply)

Cancer	Hormone imbalance	Heart problem	Hepatitis
Systemic disease	High blood pressure	Varicose veins	Immune disorders
Spinal injury	Thyroid condition	Arthritis	Lupus
Hysterectomy	Diabetes	Asthma	Insomnia
Eczema	Epilepsy	Seizure disorder	Psychological treatment
Fever blisters	Headaches (chronic)	Metal bone pins or plates	HIV/AIDS
Herpes	Frequent cold sores	Any active infection	Keloid scarring

Phlebitis, blood clots, poor circulation, blood clotting abnormalities Skin disease/skin lesions

6) Has your physician discussed concerns about raising your body temperature? No Yes, explain:
_____

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7) Do you smoke? No Yes

8) Do you follow a restricted diet? No Yes, specify: _____

9) Do you follow a regular exercise program? No Yes, describe: _____

10) What is your stress level? ___High ___Medium ___Low

11) List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

12) Do you experience any problems sleeping? No Yes

13) How many hours do you typically sleep each night? _____

14) Do you wear contact lenses? No Yes

15) List any prescription medications you take regularly:

_____

16) List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:

_____

17) Do you have any metal implants or wear a pacemaker? No Yes

18) Have you ever experienced claustrophobia? No Yes

19) Do you suffer from sinus problems? No Yes

Female Clients Only:

20) Are you taking oral contraceptives or Hormone Replacement Therapy? No Yes, specify:

_____

21) Any recent changes to or from your contraceptive or Hormone Replacement Therapy treatment? No Yes, If so, what and when? _____ _____

_____

22) Are you pregnant or trying to become pregnant? No Yes

23) Are you lactating? No Yes

24) Any menopause problems? No Yes, specify: _____

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

_____

Your Skin Health:

What would you like to achieve from your treatment today? _____

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1) Have you ever had a Facial before? No Yes

2) Have you ever had a body spa treatment before? No Yes, If yes, when and type of service:
_____

3) Have you ever had a Chemical Peel, Microderm, Dermaplane, Micro-Needling or Laser Treatment? No Yes. In the last month?
_____

4) Do you use Retin-A, Renova, Retinol or Vitamin A derivative products, Deferin, Alpha Hydroxy Acids (Lactic or Glycolic), Salicylic Acid? No Yes , if yes, describe: _____
_____

5) Have you used any of these products in the last 3 months? No Yes

6) Have you used an acne medication? No Yes, when? _____ Which drug/product? _____

7) Have you recently used any self-tanning lotions, creams or treatments? No Yes, specify:_____

8) Have you used any of the following hair removal methods in the past six weeks? No Yes, circle all that apply:
Shaving Waxing Electrolysis Tweezing Threading Depilatories

9) What areas of concern do you have regarding your:

Skin: (Please circle any that apply)

Blackheads/whiteheads	Excessive oil/shine	Rosacea	Broken capillaries	Redness/ruddiness
Sun spot/liver	Uneven skin tone	Sun damage	Wrinkles/fine lines	Dull/dry skin
Flaky skin	Dehydrated	Other_____		

Eyes:

Dehydrated	Wrinkles	Puffiness	Dark circles	Other: _____

Lips:

Dehydrated	Cracked/chapped	Other: _____

10) Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Breakout Sun Sensitivity

11) Have you ever had an allergic reaction to any of the following? (Please circle any that apply)

Cosmetics	Medicine	Food	Animals	Sunscreens	Iodine	Pollen
AHAs	Fragrance	Shellfish	Latex	Drugs	Other: _____	

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12) What skin care products are you currently using? (List brand where known)

Soap/Cleanser _____Toner _____

Mask _____ Eye Product _____

Day Moisturizer _____ Night Moisturizer _____

Serums _____ Scrubs _____

Shower Gels _____ Body Lotions _____

Makeup Products _____ _____

13) What SPF do you use on your face? _____ How often/when? _____

14) What SPF do you use on your body? _____ How often/when? _____

15) Have you had any recent tanning bed or sun exposure that changed the color of your skin? No Yes specify:_____

16) How frequently are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___Regularly

17) Have you experienced Botox/Dysport or Filler (Juvederm/Restylane) injections? No Yes, if yes when and specify injection site:

_____

18) Which of the following best describes your skin type? (Please circle one type number)

I Creamy complexion Always burns easily, never tans

II Light Complexion Always burns, tans slightly

III Light/Matte Complexion Burns moderately, tans gradually

IV Matte Complexion Seldom burns, always tans well

V Brown Complexion Rarely burns, deep tan

VI Black Complexion Never burns, deeply pigmented

19) Do you form thick or raised scars from cuts or burns? No Yes

20) Do you have Hyper-Pigmentation (darkening of the skin) or Hypo-Pigmentation (lightening of the skin) or marks after physical trauma? No Yes, describe: _____

21) Do you have any special skin problems or concerns pertaining to your face or body? No Yes, please specify:

_____

_____

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Male Clients Only:

22) What is your current shaving system? Wet shave or Electric

23) Do you experience irritation from shaving? No Yes

24) Ingrown hairs? No Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

_____

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. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Future Appointments/Contact: May I call you at your home, work or cell phone number to confirm future appointments? No Yes

May I contact you via mail/email about future promotions and news? No Yes

Client Signature: _____ Date:_____

Fitzpatrick Skin Type Evaluation

NAME_____

DATE_____

Lira™ CLINICAL

Please answer the questions below. Circle the appropriate response to each of the items to arrive at a total score.

Genetic Disposition					
Score:	**0**	**1**	**2**	**3**	**4**
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the **natural** color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin? (non exposed areas)	Reddish	Very Pale	Pale with Beige Tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
					Total Score for Genetic Disposition: _____

Reaction to Sun Exposure					
Score:	**0**	**1**	**2**	**3**	**4**
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely Burns	Never Burns
To What degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very Resistant	Never had a problem
					Total Score for Reaction to Sun Exposure: _____

Tanning Habits					
Score:	**0**	**1**	**2**	**3**	**4**
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	Over 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
					Total Score for Tanning Habits: _____

TOTAL SCORE	FITZPATRICK TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

This will confirm your skin type which will be reviewed at time of consultation.

YOUR TOTAL SCORE:_____

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Services at SkinRevision are by **Appointment Only**.

Our Team of Licensed Professionals are only paid when providing a service and only come to work when appointments are scheduled. It is how we make a living and provide for ourselves and our families. Your appointment is reserving time on our calendar and prevents another client from doing the same. We appreciate your business and thank you for respecting our time.

Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the **full amount** of your appointment and you will be required to pre-pay for all future appointments. If you have an outstanding gift certificate, pre-paid services, packages or balance in your FSA, it will be redeemed for your missed appointment. This amount must be paid prior to scheduling another appointment.

Rescheduling Policy

24 hour advance notice is required when rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment. **If an appointment is rescheduled more than once**, you will be charged, as per the statement above, a $50 fee which must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show" and will be charged for their "missed" appointment as per the statement above.

Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your practitioner will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" appointment**. Out of respect and consideration to your practitioner and other customers, **please** plan accordingly and be on time.

Pre-Paid Services/Packages/FSA Memberships/Gift Certificates*

Treatment packages and all pre-paid services* are non-refundable. Existing funds in a canceled package or received in advance for services will remain available for application to future service purchases only.

By signing this document, you agree to and understand our cancellation policy and forfeit any right to dispute/reverse or otherwise deny a credit card transaction.

*Printed:*_____

*Signature:*_____

*Date:*_____

We look forward to serving you!