Lasting Impression
CORRECTIVE SKIN CARE

CLIENT HISTORY

Name: _____ Date: _____
Phone: _____ E-Mail: _____
Street Address: _____
City, State, Zip Code: _____

Who referred you? _____

Past cosmetic history: Neuromodulator? _____ If so explain: _____

_____

Filler? _____ If so explain: _____

_____

Chemical Peels/IPL/Fraxel/Laser/Radio Frequency/LED/Microcurrent? _____
If so explain: _____

_____

_____

_____

Do you smoke? _____ If so, how often: _____
Caffeine: _____ If so, Cups per day: _____
Are you pregnant? _____ If so, how many months? _____
Are you taking birth control Pills? _____ If so what brand/type? _____
Hormone replacement? _____ If so, synthetic or biomimetic? _____
Have you had skin cancer? _____ If so, describe? _____
Are you taking oral or topical medication? _____ If so, please list: _____

_____

_____

_____

Do you have persistent acne? _____ Experience frequent breakouts, if so explain: _____

_____

Do you have any allergies to cosmetics, foods or drugs? _____ If so, please list: _____

_____

_____

Please list all skin car products you currently use including makeup: _____

_____

_____

_____

Please list skincare concerns or issues you feel are worth mentioning? _____

Please describe any important health condition you have currently: _____

Are you presently under a physician's care for any current skin condition or other issue? _____
If so, please describe: _____

How did you hear about us? _____

I understand that the products and services offered are not a substitute for medical care and any information provided by the Skincare professional is for education purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the Skincare Professional in giving better service and is completely confidential.

I fully understand and agree to the above policies.

Signature: _____ Date: _____