SKIN STUDIO KC

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CONFIDENTIAL

Skin Health Questionnaire

DATE _____
NAME _____
ADDRESS _____
CITY/STATE/ZIP _____
PHONE _____
EMAIL _____
OCCUPATION _____
REFERRED BY _____

DATE OF BIRTH _____ AGE ____ FAMILY MD _____
DO YOU SMOKE? _____ HOW OFTEN? _____ LIVE WITH SMOKER? _____
HAVE YOU BEEN TREATED FOR OR ARE YOU CURRENTLY? (Select all that apply)
☐ ACNE ☐ DEPRESSION ☐ SKIN CONDITION ☐ HIGH BLOOD PRESSURE
☐ DIABETES ☐ CANCER ☐ COLD SORES ☐ PRONE TO COLD SORES
☐ PREGNANT ☐ TRYING TO GET PREGNANT ☐ RECIEVING HORMONE THERAPY
LIST OF ALL ALLERGIES _____
LIST OF ALL MEDICATIONS YOU ARE CURRENTLY TAKING _____
_____

CURRENT LEVEL OF STRESS 1 2 3 4 5 6 7 8 9 10
NORMAL LEVEL OF STRESS 1 2 3 4 5 6 7 8 9 10

HOW MANY OUNCES OF WATER DO YOU DRINK A DAY? _____ DO YOU TAKE SUPPLEMENTS? _____
DO YOU EXERCISE? _____ IF SO, HOW OFTEN? _____ YOUR LAST SUNBURN? _____ DO YOU USE TANNING BEDS? _____
WHEN YOU GO OUT INTO THE SUN, DO YOU (Check one)
☐ ALWAYS BURN (I) ☐ USUALLY BURN (II) ☐ SOMETIMES BURN (III) ☐ RARELY BURN (IV) ☐ VERY RARELY BURN (V) ☐ NEVER BURN (VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A (Check all that apply)
☐ DERMATOLOGIST ☐ PLASTIC SURGEON ☐ AESTHETICIAN

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY (Check all that apply)
☐ SUN SPOTS ☐ SKIN LAXITY ☐ DRY / ROUGH SKIN

WHAT SKINCARE LINE ARE YOU CURRENTLY USING?_____
DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT?_____ I F NOT, WHY NOT?_____
CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN
(BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

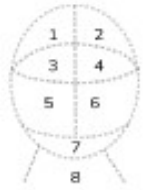
YOUR SKIN TYPE IS (Please check only one)
☐ NORMAL ☐ DRY/DEHYDRATED ☐ OILY ☐ ACNE/ACNE PRONE ☐ ROSACEA

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT)

_____REDUCTION OF FINE LINES _____REDUCTION BROWN SPOTS/SUN DAMAGE
_____REDUCTION OF REDNESS _____REDUCTION OF OIL/ACNE _____ACNE SCARS DIMINISHED

TREATMENT YOU ARE RECEIVING TODAY (Please Select One)

☐ ACNE LIFT PEEL®
☐ PEEL LIGHTENNING LIFT®
☐ PEEL BETA LIFT™
☐ PERFECTION LIFT™
☐ PEEL THE SIGNATURE FACELIFT®
☐ IMAGE FACIAL



◯ 1 Left Forehead
◯ 2 Right Forehead
◯ 3 Left Eye Area
◯ 4 Right Eye Area
◯ 5 Left Cheek
◯ 6 Right Cheek
◯ 7 Chin
◯ 8 Neck

Thank you for completing this confidential questionnaire.
This information will allow me to provide the optimum products during your service.

_____ _____
Client Signature Date