Client Confidential Skin Heath Questionnaire

Hello my lovely customer, and thank you for trusting B. o.T. B. to facilitate your skincare journey. This information will allow your facial specialist to provide the optimum Beauty on The Beat Skincare products and services.

What are your skin care goals? What do you hope to accomplish? YOUR SKIN IS AN INVESTMENT that will last for a lifetime!

The 80/20 Rule

It is a proven fact that 80% of your skin care results are going to come from what you do outside of the treatment room (Homecare Routine and Proper Product Usage, Lifestyle Factors, Diet) and the other 20% comes from what is done in the treatment room (Monthly Facial Treatments, Dermaplaning, LED Light Therapy). There is an old saying when it comes to addressing Skincare concerns, "It Didn't Happen Overnight". Are you ready and willing to commit?

Client Name:_____

Date OF Birth: _____

Address:_____

Gender: _____

Occupation:_____

Hereditary background:_____

How did you hear about us?_____

Health History

Have you seen a Dermatologist in the past year? * yes no

If yes, list Dermatologist's name, contact info and reason for the visit:

Client Confidential Skin Heath Questionnaire

Are you now or have you been under the care of physician within the last two years? * yes no

If yes, please provide the physician's name and phone number:

HAVE YOU BEEN TREATED FOR: (PLEASE CHECK ALL THAT APPLY) *

ACNE DEPRESSION SKIN DISEASE HIGH BLOOD PRESSURE COLD SORES

DIABETES CANCER NONE OF THE ABOVE

List all medications or other the over-the-counter medications (including vitamins, herbal supplements, aspirin, etc.) you are currently taking *

Have you used an acne medication? * yes no

If yes, when and which drug?

Do you use retin-A, Renova, Adapalene Hydroxy Acid, Deferin, Glycolic acid, AHA, Salicylic Acid or Retinol/Vitamin A Derivative products? * yes no

Have you used any of these products in the last 3 months? * yes no

Client Confidential Skin Heath Questionnaire

List all skin allergies to medication or topical creams

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

☐ Rash ☐ Irritation ☐ Peel ☐ Sun Sensitivity ☐ Breakout

If yes, Please Explain:

Have you ever had an allergic reaction to any of the following? (Please check all that apply) *

☐ Cosmetics ☐ Medicine ☐ Food ☐ Animals ☐ Sunscreens ☐ Iodine ☐ Pollen

☐ AHAs ☐ Fragrance ☐ Shellfish ☐ Latex ☐ Drugs ☐ Other

If other, please explain:

Are you allergic to Benzyl Peroxide? * ○ yes ○ no

Are you allergic to Aspirin? * ○ yes ○ no

Does your skin get red after exfoliation? * ○ yes ○ no

In general, is your skin red and sensitive? * ○ yes ○ no

Does the redness onset with foods or products? * ○ yes ○ no

Do you have any metal implants or wear a pacemaker? * ○ yes ○ no

Do you suffer from sinus problems? * ○ yes ○ no

Have you ever experienced claustrophobia? * ○ yes ○ no

Do you have intolerance to heat or cold? * ○ yes ○ no

Do you wear contact lenses? * ○ yes ○ no

Client Confidential Skin Heath Questionnaire

Are you on hormone therapy? * yes no

Lifestyle Factors

What kinds of professional services have you had in the past year? *

Have you received any of the following procedures? (Please check all that apply) *

Chemical Peel Microdermabrasion Dermaplaning Facial Ultrasound Facial
Laser Hair Removal Injectables EyeLash/Eyebrow Tint Waxing Sugaring
Skin Care Products Laser Treatments I Am Not Familiar With These Services

How was your experience with that?

Would you be interested in cosmetic surgery? *

yes no

If yes, on what body part?

Have you been exposed to the sun or used a tanning bed in the last 48 hours? * yes no

Do you currently have a sunburn/windburn or red face? * yes no

When was your last sun burn?

Client Confidential Skin Heath Questionnaire

When you go out into the sun, do you (select one) *

☐ Always Burn I ☐ Usually Burn II ☐ Sometimes Burn III ☐ Rarely Burn IV

☐ Very Rarely Burn V Never Burn VI

Do you work outside? * ○ yes ○ no

Do you spend a lot of time outside? * ○ yes ○ no

Do you wear SPF (Sun Block)? * ○ yes ○ no

If no, why? *

Do you wear SPF in the winter? * ○ yes ○ no

Do you wear SPF all year round? * ○ yes ○ no

How often do you apply SPF?

Do you smoke? * ○ yes ○ no

If yes, how often?

Living with a smoker? * ○ yes ○ no

Client Confidential Skin Heath Questionnaire

Do you exercise? * yes no

If yes, how often?

How many of ounce of water do you drink daily? *

How much caffeine do you consume daily?

Do you experience any problems sleeping? * yes no

How many hours do you typically sleep each night? *

Do you take hot showers? * yes no

Do you use hot water on your face? *

Select your current level of stress: 1 – 10 Highest (Circle One) * 1 2 3 4 5 7 8 9 10

SKIN Concerns

After washing your face in the morning what time of day do you notice it looks or feels oily?

Do you break out? * yes no

When, where and how often? What do you experience when this happens? *

Client Confidential Skin Heath Questionnaire

When you breakout do you have: (Please check all that apply) *

☐ Cysts ☐ Whiteheads ☐ Blackheads ☐ Red Rash like Inflammation

☐ I don't experience breaks outs

Do you form thick or raised scars from cuts or burns? * ○ yes ○ no

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? * ○ yes ○ no

If yes, please describe:

What areas of concern do you have about your skin? (Please check all that apply) *

☐ Blackheads/Whiteheads ☐ Breakouts/Acne ☐ Blackheads Broken Capillaries ☐ Congestion

☐ Discoloration ☐ Dull/Dryness ☐ Fines Lines ☐ Flaky Skin ☐ Oily Skin ☐ Rosacea

☐ Telangiectasia ☐ Uneven Skin Tone ☐ Sun Damage ☐ Sun Spots/ Liver Spots ☐ Melasma

☐ Other

If other, please explain:

What areas of concern do have regarding your eyes? (Select all that apply) *

☐ Dehydration ☐ Wrinkles ☐ Puffiness ☐ Dark Circles ☐ Other

If other, please explain:

Client Confidential Skin Heath Questionnaire

What areas of concern do you have about your lips ? (Select all that apply) *

☐ Dehydration ☐ Dry/Chapped Lips ☐ Other

If other, please explain:

Is there one thing you really like about your skin?

Select how you feel about the over all quality of your skin: (1) being bad (10) fantastic (Circle one)*

1 2 3 4 5 6 7 8 9 10

What is your skin type? (Select all that apply) *

☐ Normal ☐ Dry/Dehydrated ☐ Oily ☐ Acne/Ace Prone ☐ Rosacea ☐ Combination

☐ Sensitive ☐ I'm not sure

What are your skin care goals? *

Please indicate services for which you are interested in: *

☐ Hydrodermabrasion ☐ Microdermabrasion ☐ Dermaplaning with Peel ☐ Chemical Peel

☐ Micro Current ☐ Microneedling ☐ I'm Note Sure I Just Want To Improve The Overall Health Of My Skin

How long do you spend on your skin care routine every day?

Client Confidential Skin Heath Questionnaire

Where do you buy your products? *

☐ Drug Store ☐ Professional skincare line

What skin care products are you currently using? {Please list brand names when available) Soap: Cleanser: Toner: Exfoliator: Mask: Sunscreen: Makeup Products: Eye Product: Day Moisturizing Cream: Scrubs: Body Lotion: Shower Gels: Night Cream: *

Is there a line of products that you particularly like?

Do you change your skin care routine through the seasons? * ○ yes ○ no

Females Only

Are you pregnant or nursing * ○ yes ○ no

Trying to get pregnant? * ○ yes ○ no

Are you taking oral contraceptives? * ○ yes ○ no

If yes, list:

Any recent changes to or from your contraceptive treatment? *

Client Confidential Skin Heath Questionnaire

Is so, what and when?

Any menopause problem? * yes no
If yes, specify:

Are you interested in aroma therapy? * yes no

If yes, what scent do you prefer?

Lavender Eucalyptus Citrus Floral Wood Herb

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. *

Client Signature: _____
Date_____
Parent or Guardian Signature (in case of a minor): _____
Date_____