sana vida
CLINIC & STUDIO

SKINCARE INTAKE

Name _____

Address _____

City _____ State _____ Zip _____

E-Mail _____

Phone: Home _____ Cell _____ Work _____

Birthday _____ Age _____

How did you hear about us?

Your Health

Within the last year, have you been under a dermatologist or physician's care? yes no

If yes, please specify:

Within the last nine months, have you undergone any surgery? yes no

If yes, please specify:

List any prescription or over-the-counter medications, supplements, vitamins, etc., taken regularly:

Do you smoke? yes no

Do you exercise regularly? yes no

Do you follow a restricted diet? yes no

Do you wear contact lenses? yes no

Do you have metal implants, a pacemaker or body piercing? yes no

Rate your level of stress on a scale of 1 to 4 (1 = low, 4 = high): 1 2 3 4

Your Skin

Do you have any special skin problems pertaining to your face or body? yes no

If yes, please specify:

What skin care products are you currently using? (circle all that apply):

Face: soap cleanser toner moisturizer masque exfoliator eye products

Body: soap shower gel scrubs oil body moisturizer depilatory self tanner

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Exfoliation History

Have you had a chemical peel, microderm, or any resurfacing treatment? yes no

In the last month? yes no

Do you use Accutane, Retin A, Renova, or any other prescription skin products? yes no

In the last 3 months? yes no

Are you currently using any products that contain the following ingredients?

glycolic acid lactic acid exfoliating scrub hydroxy acid vitamin a derivatives

Moisture Hydration

How much plain water do you consume daily?

How many alcoholic beverages do you consume weekly?

Do you ever experience these conditions on your skin: flakiness tightness dryness

What spf sunscreen do you use on your face? body?

Do you sunbathe or use tanning beds? yes no

Capillary Activity

Do you burn easily in moderate sunlight? yes no

Do you blush easily when nervous? yes no

Do you have a tendency toward redness? yes no

Do you suffer from sinus problems? yes no

Oil Secretion

Do you ever experience oily shine during the day? yes no

Do you ever experience skin breakouts? yes no

Nerve Activity

Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) yes no

Do you ever experience a burning, itching sensation on your skin? yes no

What is your pain threshold?

Have you ever experienced claustrophobia? yes no

What type of massage pressure do you prefer?

Have you ever had a reaction to any of the following?

cosmetics medicine iodine pollen food hyroxy acids animals fragrance sunscreens other:

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Female Clients Only

Are you taking oral contraception? yes no

Are you pregnant or trying to become pregnant? yes no

Are you lactating? yes no

Male Clients Only

What is your current shaving system? electric wet shave

Do you experience irritation from shaving? yes no

Do you experience ingrown hairs? yes no

Questions to Discuss Every Visit

Are you currently having or due for your menstrual period? yes no

Have you started any new medication since your last visit? yes no

Have you had any recent dental x-rays? yes no

What are your skin care goals?

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature _____ **Date** _____

This intake form is to correctly evaluate your special skin care needs. This information is confidential and may be disclosed only to staff members, risk or quality improvement personnel to assess the quality of care and will not be passed on to a third party.