Client Consultation

Name: ____________________________________ Date of Birth: __________________________

Address: ____

Home Phone: ( ) ____________________ Cell Phone: ( ) ________________________

E-mail address: _______________________________ Referred by: ___________________________

I am interested in: (Please check all that apply)

- Botox- for fine lines
- Anti-aging
- Freckles, sun damage, age spots, birthmarks
- Acne scars, facial wrinkles, line lines, loose skin, enlarged pores, smoother texture
- Redness, facial veins, red dots
- Skin tightening
- Non-invasive fat reduction
  - Muffin top
  - Love handles
  - Bra fat
  - Saddle bags
  - Double chin
  - Inner thighs
  - Outer thighs
- Skin care regimen/products
- Facial treatments
- Chemical peels
- Other, Please specify ____

Do you use sunscreen? YES / NO If yes what is the SPF? ____________________

When you sunbathe, how does your skin respond?

- Always burn, never tan
- Usually burn, tan with difficulty
- Sometimes burn, tan about average
- Almost never burn, tan very easily
- Rarely burn, tan easily
- Never burn, Always tan

Medical History:

- Acne
- Arthritis
- Autoimmune Disorder
- Blood Disorders
- Cancer
  - Radiation
  - Chemo
- Diabetes/Diabetic Neuropathy
- Herpes
- Hirsutism
- Kidney Disease
- Vitiligo
- Melanoma
- Port Wine Stain

- Psoriasis
- Pacemaker
- Skin Pigmentation
- Shingles
- Polycystic Ovarian Syndrome
- Hormonal Therapy
- Hormonal Imbalances
- Keloid Scars/Other Scar

Additional Questions:

1. Are you currently being treated for any conditions not listed? If yes, please specify.

   ____

2. Are you currently taking any medications, including herbal preparations, medical patches or Aspirin? If yes, please specify. ____

   ____

3. Do you have any allergies? If yes, please specify. ______________________________________
4. Have you ever used (or currently using) Retin-A or glycolic acid? If yes, please specify.

   ____

5. Have you ever used (or are currently using) Isotretinoin? If yes, please specify. _________________
6. Have you ever had a chemical peel? If yes, please specify. ________________________________
7. Have you had any laser treatments? If yes, please specify. ________________________________
8. What products are you currently using on your skin? ____________________________________
9. Do you have a pacemaker? ____
10. Have you ever been treated by an endocrinologist (hormone imbalance)? If yes, please specify.

    ____

11. Are you currently pregnant? ____
12. Have you had filler or Botox/Dysport injections in the area to be treated? If yes, please specify.

    ____

13. Do you have any skin sensitivities or allergies? If yes, please specify.

    ____

Please sign below to indicate all the information on this form is accurate and complete.

____

Patient's Name **Date**