CONFIDENTIAL ANALYSIS

ALL INFORMATION COLLECTED FOR THE BENEFIT OF TREATMENTS.
YOUR DETAILS ARE KEPT STRICTLY CONFIDENTAL AT ALL TIMES.

THE SKIN FIX

CLIENT DETAILS

Full Name_____ Date of First Visit_____

Address _____ City, State, Zip _____

Phone _____ Email _____

Occupation _____ DOB _____ Referred By _____

Ethnicity [ ] *Latino* [ ] *Caucasian* [ ] *African American* [ ] *Asian* [ ] *Other*

SKIN

Check the areas you would like to improve with your skin: (check all that apply)

[ ] *Color*	[ ] *Freckles*	[ ] *Texture*	[ ] *Wrinkles*	[ ] *Eye area*
[ ] *Firmness*	[ ] *Plumpness*	[ ] *Capillaries*	[ ] *Smoothness*	[ ] *Neck area*
[ ] *Decolletage*	[ ] *Breakouts*	[ ] *Blackheads*	[ ] *Acne*	[ ] *Premature aging*
[ ] *Dryness*	[ ] *Congestion*	[ ] *Pore size*	[ ] *Scarring*	

List skin care products currently using:

_____

_____

Have they achieved the results you want? [ ] *Yes* [ ] *No*

Do you use sunscreen daily? [ ] *Yes* [ ] *No*

MEDICAL HISTORY

Do you smoke? [ ] *Yes* [ ] *No*

Have you in the past or present or had any of the following problems? (check all that apply)

[ ] *Epilepsy* [ ] *Diabetes* [ ] *Thyroid* [ ] *Heart Problems*

[ ] *Hysterectomy* [ ] *Hormonal Imbalance* [ ] *Depression* [ ] *High / Low Blood Pressure*

[ ] *Cancer* [ ] *Other*: _____

Have you had plastic surgery? [ ] *Yes* [ ] *No* If so; Date _____

Surgeon's Name _____ Description _____

Have you had Botox or Fillers? [ ] *Yes* [ ] *No* If so; Date _____

Are you currently using Retin-A, Retinal, AHA or any peeling agent? [ ] *Yes* [ ] *No*

If so; How Long _____ Strength _____ Results _____

Do you suffer from claustrophobia or anxiety? [ ] *Yes* [ ] *No*

Any known allergies to cosmetics, food, medication, animals, pollens or metals?

[ ] *Yes* [ ] *No* _____

Do you have a tendency to keloid scar? [ ] *Yes* [ ] *No*

Have you had a skin peel in the past 2 years? [ ] *Yes* [ ] *No*

Results _____ Brand(s) _____

MEDICATION

Have you been under a physicians care during the past 3 years? [ ] *Yes* [ ] *No*

Are you currently taking medication? [ ] *Yes* [ ] *No*

If so; How Long _____ Name(s) _____

_____

Are you currently taking accutane or roaccutane? [ ] *Yes* [ ] *No*

If so; How Long _____ Name(s) _____

_____

Are you currently taking Dietary or Herbal Supplements or Vitamins? [ ] *Yes* [ ] *No*

If so; How Long _____ Name(s) _____

_____

How much water do you drink daily? (# of glasses) _____

I give permission to photograph and/or film treatment progress. Material may be used for promotional purposes. [ ] *Yes* [ ] *No*

Client Signature _____ Date _____

certifies above is correct