Elegance Esthetic

Client Information

Last Name:_____First Name:_____
DOB:_____ Sex: Female / Male
Address:_____City/State:_____
Phone Number:_____
Email:_____

Emergency
Contact:_____Relationship:_____
Phone Number:_____

How did you hear about us?
_____

What skin improvement would you like to see?
_____
Women: Are you pregnant or lactating? **Yes / No**
Men: Do you experience irritation from shaving? **Yes / No**

Health History

Yes / No Cancer (skin or other)
Yes / No Diabetes
Yes / No Autoimmune Disease (Lupus, RA, MS etc.)
Yes / No Thyroid Disease
Yes / No Neck/ Back Pain
Yes / No Heart Problems/ Blood Pressure

Yes / No Infection (Virus,bacteria)
Yes / No HIV/AIDS
Yes / No Eye Disorder
Yes / No Chronic Pain (Fibromyalgia, Migraine etc.)
Yes / No Epilepsy
Yes / No Hormones Issues
(PCOS, Endometriosis, Menopause)

Yes / No Allergies (Please List)

_____

Skin History

Yes / No Recent Surgery (General) the last 6 months?
Yes / No Recent Surgery (Cosmetic) the last 6 months?
Yes / No Recent cosmetic injections? (Botox, Filler, etc.)
Yes / No Recent hair removal? (Waxing, Laser electrolysis)
Yes / No Are you under a doctor's care for skin issues?
Yes / No Laser treatments/IPL within the last month?

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Yes / No Chemical peels within the last month?
Yes / No Loss of skin sensation?
Yes / No Recent sunburn?

Daily Medications

- ☐ Accutane
- ☐ Antibiotic
- ☐ Sleep/Anxiety
- ☐ Hormones
- ☐ Retin-A
- ☐ Anti-Depressant
- ☐ Pain/NSAIDS
- ☐ Skin Disease
- ☐ Diabetes
- ☐ Heart/Blood Pressure
- ☐ Blood Thinner
- ☐ Thyroid
- ☐ Corticosteroid
- ☐ Anti-Androgen
- ☐ Other:
  _____
  _____
  _____

Lifestyle

Do you sleep from 6-8 hours a night? **Yes / No** If no, how many hours?_____
Do you smoke? **Yes / No** Cigarettes or other:_____
Do you have chronic stress? **Yes / No** What is your level:_____
Do you exercise regularly? **Yes / No**
Do you use hormone replacement therapy? **Yes / No**
Do you get daily UV exposure? **Yes / No**
Do you drink more than 7 drinks a week of alcohol? **Yes / No**
Do you eat at least 3 servings of vegetables a day? **Yes / No**
Is your intake of sugar more than 100 cals a day? **Yes / No** (Ex: soda, desserts, other processed foods)
Do you drink 8-10 glasses of water a day? **Yes / No**
Do you take probiotics daily? **Yes / No**
Do you take vitamin D3 daily? **Yes / No**
Do you take a multivitamin daily or omega oils? **Yes / No**

Service Consent

I understand, I have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosure. I understand that withholding information or providing misinformation May result in contra indications and/or irritation to the skin from treatments received. I understand the appointment cancellation policy. The treatment I receive here is voluntary, and I released this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature:_____**Date:**_____

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