Âme Skin
Studio

Date: _____

First Name_____ Last Name_____

Date of Birth _____/_____/_____

Address: _____ City, State, Zip_____

E-Mail Address _____@_____

Would you like to receive our newsletter with coupons and promotions? Yes ☐ No ☐

Phone: (Cell) _____ (Home) _____ (Work)_____

Dermatologist/Physician _____ Phone: _____

Your occupation: _____

Referred by: Friend ☐ Mailer ☐ Gift Certificate ☐ Other ☐ _____

_____

1. Is this your first facial? Yes ☐ No ☐

2. Is this your first Body Treatment? Yes ☐ No ☐

3. What is the reason for your visit today? _____

_____

4. What special areas of concern do you have? _____

_____

5. Are you presently under a physician's care for any current skin condition or other problems?

Yes ☐ No ☐ If yes, for what? _____

6. Do you wear contact lenses? Yes ☐ No ☐

7. Do you smoke? Yes ☐ No ☐

8. Are you allergic to latex or vinyl? Yes ☐ No ☐

9. Have you ever had skin cancer? Yes ☐ No ☐

10. Have you used the following topical medications within the last 2 weeks?

Azlex ☐ Differin ☐ Renova ☐ Retin-A ☐ Tazarac ☐ Glycolic or alpha hydroxy acids ☐ Other ☐

11. Are you now using or have you ever used Accutane? Yes ☐ No ☐

If yes, when and for how long?_____

12. Do you have acne? Yes ☐ No ☐ Experience frequent blemishes? Yes ☐ No ☐

13. Do you have any allergies to cosmetics, foods or drugs? Yes ☐ No ☐ If yes, please list _____

_____

14. Are you presently taking medications, oral or topical? Yes ☐ No ☐

If yes, please list all medications: _____

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15. What products do you presently use?

Soap ☐ Facial Cleanser ☐ Toner ☐ Sunscreen ☐ Scrub ☐ Mask ☐ Creams ☐ Other _____

16. Please check if you are affected by any other following:

Asthma ☐ Hepatitis ☐ Metal Pins/Plates ☐ Cancer ☐ Herpes 1 or 2 ☐ Pacemaker ☐

Cardiac problems ☐ High Blood Pressure ☐ Skin Disease/other ☐ Eczema ☐ Hysterectomy ☐

Sinus Problems ☐ Fever ☐ Blisters ☐ Immune Disorders ☐ Urinary or kidney problems ☐

Headaches (Chronic) ☐ Lupus ☐

Please explain above problems or list any significant others: _____

_____

17. Do you sun bathe or use tanning beds? Yes ☐ No ☐ Have you used within the last two weeks? ☐

18. Are you claustrophobic? Yes ☐ No ☐

19. What kind of pressure do you prefer in a massage? Light ☐ Medium ☐ Deep ☐

20. Do you receive Botox or Fillers? Yes ☐ No ☐

If so, when was your last injection? _____

21. Have you had any recent facial procedures? (Ex. Microneedling, Fractional, Peels, Microdermabrasion...)

Yes ☐ No ☐ If so, when? _____

Female Clients Only:

22. Are you pregnant or planning pregnancy? Yes ☐ No ☐

I understand the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature.

I fully understand and agree with all of the above: (ONE SIGNATURE PER VISIT)

_____ _____

CLIENT SIGNATURE/GUARDIAN DATE