**NEW CLIENT INFORMATION FORM**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *May we call to confirm your appt? Please use the numbers that you wish us to call.*

E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *We notify our customers about treatment specials and discounts on product by email. (We do not disclose this information to anyone.)*

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *If referred by a friend, please let us know, as we offer discounts for referrals.*

ALLERGIES? YES NO If Yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any reactions to medications, drugs, cosmetics, fabrics, rubber, latex, etc. and type of reaction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications and prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? YES NO If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently removing hair by any of the following methods?

\_\_\_\_\_Waxing \_\_\_\_\_Electrolysis \_\_\_\_\_Tweezing \_\_\_\_\_Laser Hair Removal \_\_\_\_\_“Nair” type products If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What area(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had:

\_\_\_\_\_Microdermabrasion \_\_\_\_\_Intense pulse light treatment \_\_\_\_\_Chemical peel \_\_\_\_\_Laser vein treatment \_\_\_\_\_Facial \_\_\_\_\_Sclerotherapy \_\_\_\_\_Laser hair removal \_\_\_\_\_Laser resurfacing \_\_\_\_\_Collagen replacement therapy \_\_\_\_\_Cosmetic surgery \_\_\_\_\_Botox \_\_\_\_\_Juvederm \_\_\_\_\_Perlane \_\_\_\_\_Restylane \_\_\_\_\_Dysport \_\_\_\_\_Radiesse \_\_\_\_\_Collagen

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were you happy with your results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormones (females only):

\_\_\_\_\_Regular periods \_\_\_\_\_Going through menopause

\_\_\_\_\_Take birth control or estrogen \_\_\_\_\_During pregnancy, did you ever get hyper pigmentation or masking?

Do you sun tan frequently outdoors or indoors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you use any sunless tanning products? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When were you last exposed to the sun/tanning booth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have any personal/family history of skin cancer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you tan? \_\_\_\_\_Burn \_\_\_\_\_Usually Burn \_\_\_\_\_Burn then tan \_\_\_\_\_Always tan

Vascularity: Broken capillaries on: \_\_\_\_\_Nose \_\_\_\_\_Cheeks \_\_\_\_\_Chin

Pigmentation \_\_\_\_\_Even \_\_\_\_\_Uneven \_\_\_\_\_Birthmark \_\_\_\_\_Pregnancy Mark

Acne: Do you have a history of: \_\_\_\_\_Pimples \_\_\_\_\_Whiteheads \_\_\_\_\_Blackhead

\_\_\_\_\_Forehead \_\_\_\_\_Enlarged pores \_\_\_\_\_Entire face \_\_\_\_\_Flakiness \_\_\_\_\_Acne scars

What do you want to improve about your skin? \_\_\_\_\_Fine lines \_\_\_\_\_Large pores \_\_\_\_\_Frown lines \_\_\_\_\_Worry lines \_\_\_\_\_Acne Scars \_\_\_\_\_Crow’s feet \_\_\_\_\_Marionette lines \_\_\_\_\_Deep smile lines \_\_\_\_\_Color irregularities \_\_\_\_\_Facial scars \_\_\_\_\_Cellulite \_\_\_\_\_Stretch marks \_\_\_\_\_Sun damage \_\_\_\_\_Overall skin tone

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your skin is: \_\_\_\_\_Oily \_\_\_\_\_Resilient \_\_\_\_\_Dry \_\_\_\_\_Sensitive \_\_\_\_\_T-zone/combination \_\_\_\_\_Not sure

Please list all the products you are currently using and the **BRAND NAME**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Health History:** \_\_\_\_\_Excessive sun exposure \_\_\_\_\_Pregnant/lactating \_\_\_\_\_Connective tissue disorder or autoimmune disease \_\_\_\_\_Allergy to lidocaine (Xylocaine) \_\_\_\_\_History of serious allergies (anaphylaxis) \_\_\_\_\_History or facial cold sores or genital herpes \_\_\_\_\_History of hypertrophic scarring (thick, raised scars) \_\_\_\_\_Bleeding tendency \_\_\_\_\_Use of blood thinner, aspirin, or NSAIDS \_\_\_\_\_Active inflammation or acne \_\_\_\_\_Communicable disease \_\_\_\_\_HIV or exposure to person with known HIV \_\_\_\_\_Hepatitis or known exposure to Hepatitis A, B, or C \_\_\_\_\_Taking immunosuppressive drugs, steroids \_\_\_\_\_History of Accutane use (in the past 6 months) \_\_\_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The information on this form is correct to the best of my knowledge.** Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_