Schenden's
medical day spa

SKIN ASSESSMENT FORM

Client Name: ______________________ Age** ________ **Date of birth:** MM/DD/YY

Address: ______________________ **City:** __________ **State:** __________ **Zip:** __________

Phone: ______________________ ______________________ ***Email:*** ______________________

Home ❍ Cell ❍ Work ❍ Other ❍ *Home ❍ Cell ❍ Work ❍ Other ❍*

How did you hear about us? ______________________

Emergency Contact: ______________________ Phone: __________ Relationship: __________

***IF under 18: Information of responsible adult*

Name: ______________________ *Relationship To Client:* ______________________

Contact Phone: ______________________ *Signature/authorization* ______________________

MEDICAL HISTORY

Allergies: ○ Latex ○ Cosmetics ○ Seasonal ○ Foods ○ Metal(s)

List any Medication allergies: __________ Other: __________

Are you currently using ○ Retin-A ○ Alpha- Hydroxy ○ Acutane ○ Hydroquinone skin care products? *(check if yes)*

☐ Yes ☐ No Are you taking any anti-inflammatory medication or steroid?

☐ Yes ☐ No Have you had any aspirin or blood thinning products within the past 7 days?

☐ Yes ☐ No Have you had any mood altering drugs within the past 8 hours?

Do you have sensitivities to: ○ heat ○ cold ○ smell other: __________

Are you currently using: ☐ Yes ☐ No Hearing Aid/ Pacemaker ☐ Yes ☐ No Contact Lenses

Please check all current or past conditions that apply:

○ Vitiligo	○ Headache/Migraine	○ Diabetes	○ Heart Condition	○ Fibromyalgia	○ Arthritis
○ Rosacea	○ Sinus Problems	○ Asthma	○ Epilepsy/ seizures	○ Lupus	○ Hepatitis A/B/C
○ Keloid Scarring	○ Anxiety/Depression	○ Numb/Tingling	○ Bleeding disorder	○ HIV/AIDS	○ Lymph Edema
○ Psoriasis/Skin Rash	○ Dermatitis/ Eczema	○ Staph Infection	○ Thyroid Condition	○ Glaucoma	○ Smoker
○ Hyper-pigmentation	○ Cold Sores/Shingles	○ Blood Pressure	○ Dizziness/Vertigo	○ Body Metal	

☐ Yes ☐ No Have you or any family member had skin cancer? If yes, who __________ Location __________

Other conditions please explain: ______________________

____

____

For Women Only: *Please check all that apply*

○ Pregnant ○ Lactating ○ Going through menopause ○ Polycystic Ovarian Disease

NUTRITIONAL INFORMATION

Please list any Vitamins/Supplements/Herbal Remedies : ______________________

____

Please list any oral medication you currently take: ______________________

____

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Skin Care Treatment

☐ Yes ☐ No Is this your first facial? Date of last facial service: ____________

What are your areas of concern *(please check all that apply)*

○ Wrinkles/Aging Skin ○ Acne Scarring ○ Acne/Pimples ○ Cystic Acne ○ Sun Damage ○ Cellulite

○ Dark Circles ○ Dull/Uneven Skin ○ Enlarged Pores ○ Skin Elasticity ○ Excess Hair Other: ____________

What would you like to improve? ____________

Have you had/used or currently have/using any of the following?

○ Chemical /Enzyme Peel ○ Dermabrasion ○ Tanning Beds/Sunless Tanning

○ Bleaching Cream ○ Waxing ○ Topical Antibiotic/Acne Medications

Facial Filler: *Date* ________ *Area(s)* ________ Botox *Date* ________ *Area(s)* ________

Cosmetic Surgery: *Date* ________ *Area(s)* ________ Mole Removal: *Date* ________ *Area(s)* ________

Laser Treatment: *Date* ________ *Area(s)* ________ Other: ________

Hypersensitivity and Skin Fragility:

☐ Yes ☐ No Have you ever had a skin allergy or sensitivity? (ie: rash, irritation, peeling, swelling, hives, etc.)

If yes, what caused the reaction ____________

☐ Yes ☐ No Do you “flush” or “redden” easily when you eat spicy food, drink alcohol, or go in the sun?

Pigmentation:

When exposed to the sun, do you: Always Burn Usually Burn Sometimes Burn Rarely Burn Never Burn

What is your ethnicity/nationality? ____________

☐ Yes ☐ No During pregnancy, did you ever get hyperpigmentation or a “pregnancy mask”?

Acne: Breakout type(s) *Please check all that apply*

○ hormonal ○ never or rarely ○ occasional ○ Always have a pimple or some type of breakout

Home Skin Care

Cleanser: brand: ____________ ☐ Yes ☐ No Does it contain Glycolic/Lactic/Salicylic Acid or Enzyme

Moisture: Night Cream brand: ____________ Active Ingredient: ____________

Day Cream brand: ____________ Active Ingredient: ____________

Sunscreen brand ____________ SPF: ____________

Other skin care products being used: ____________

Please Initial

________ I agree to follow post procedure guidelines recommended and notify therapist with any concerns.

________ I understand that aesthetic services offered are not a substitute for medical care, and any information provided by the therapist(s) is confidential and for educational purposes only.

________ I do not need a doctor’s release for any services provided.

________ I have filled out the history sheet correctly and accurately. I understand failure to inform the therapist of any conditions could affect treatment result.

I hereby give my consent to receive spa treatments and release this business as well as the therapist(s) from any current or future claims with treatment(s).

I am aware, depending on the treatment(s), I may experience some temporary mild discomfort such as soreness, bruising, stinging, warm flushing or redness as well as other possible effects explained to me. Those prone to cold sores may have a breakout after treatment. Valtrex is recommended.

*Client Signature*** *Date* *Technician Signature* *Date*

****If client is under 18- Signature of Responsible Adult Required*