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DOCTOR'S APPROACH MED SPA CLIENT ASSESSMENT PROFILE

Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip code: _____ Phone: _____ Date of Birth: _____

We often send out e-mail newsletters with updates on anti-aging, our free community service events, and the latest news in skin health. Would you be interested in providing us your e-mail address for this purpose? ___ Yes, my e-mail address is: _____ ___ No thanks

1. What are your skin care concerns? Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Clogged Pores |
| <input type="checkbox"/> Brown Spots (uneven skin tone) | <input type="checkbox"/> Excessive Oiliness |
| <input type="checkbox"/> Upper lip lines-Deep <input type="checkbox"/> Fine <input type="checkbox"/> | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Blackheads | <input type="checkbox"/> Whiteheads |
| <input type="checkbox"/> Pimples-Often <input type="checkbox"/> Sometimes <input type="checkbox"/> | <input type="checkbox"/> Dry Patches |
| <input type="checkbox"/> Hard Bumps Under Skin | <input type="checkbox"/> Freckles |
| <input type="checkbox"/> Wrinkles-Deep <input type="checkbox"/> Fine <input type="checkbox"/> | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Visible Exposed Blood Vessels | <input type="checkbox"/> Hair Growth- <input type="checkbox"/> Excessive <input type="checkbox"/> Ingrown |

2. From the above list of concerns, what 3 are most important to you? Can you point them out?

1. _____
2. _____
3. _____

3. Have you been seen by a dermatologist and/or a plastic surgeon? _____

If so, for what reason? _____

4. Please list all medications that you take regularly. Include hormones, vitamins, etc.

5. Are you taking Accutane? _____

If yes, for how long? _____

6. Do you use Retin A, Renova, Tazorac, Avage, Glytone, Azelex, or Differin? _____

If yes, for how long? _____

7. **Do you have any medication- or skin-related allergies?** _____

If yes, please list allergies: _____

8. Are you pregnant or lactating? _____

9. Have you had any of the following procedures?

Laser resurfacing	Yes ___ No ___	Date _____
Light chemical peel	Yes ___ No ___	Date _____
Medium/Heavy chemical peel	Yes ___ No ___	Date _____
Botox	Yes ___ No ___	Date _____
Juvederm or other fillers	Yes ___ No ___	Date _____
Cosmetic/reconstructive surgery	Yes ___ No ___	Date _____

10. Professional Analysis—Oil Secretion Level

- a. How does your face feel upon awakening? Oily ___ Dry/Itchy ___ Normal ___
- b. After cleansing your face in the morning, how soon do you notice any oily shine?
Before Noon ___ Noon to 3 p.m. ___ Not at all ___
- c. Do you ever experience skin breakouts? ___ Yes ___ No

11. Do you ever experience tightness or flaking of your skin? ___ Yes ___ No

12. Following an acne breakout, does your skin turn red or darken? ___Yes ___No How long does this last?

13. How does your skin react to insect bites? _____

14. If you have had previous surgeries, did your incision heal quickly? ___Yes ___No Did you experience thickening of the scar or a raised, red, or darkened scar at the incision site? ___Yes ___No.

12. Do you smoke? ___Yes ___No (Smoking promotes free radical formation, which causes collagen breakdown, which leads to premature aging. Excessive smoking will make it more difficult to attain and maintain results)

13. Please check any health conditions you have had or are now experiencing:

- | | | |
|--|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Metabolic Disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Silicone/Zyderm Injections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Heart Problems | |
| <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> Thyroid Problems | |

14. Do you have a history of fever blisters or cold sores? ___Yes ___No

15. Do you frequent tanning booths? ___Yes ___No

16. Have you ever received a facial or body treatment in the past? ___Yes ___No

17. What is your home skin care routine? Please include brand names.

Product	AM	PM
Cleanser	_____	_____
Toner	_____	_____
Topical Treatment	_____	_____
Moisturizer	_____	_____
Eye Cream	_____	_____
Sunscreen/Sunblock	_____	n/a
Exfoliant/Mask	_____	_____
Other	_____	_____

18. Do you use sunscreen or sunblock daily on a year-around basis? ___Yes ___No
If yes, what strength? _____

19. Do you wear contact lenses? ___Yes ___No

20. How did you hear about us?

- Friend (Name: _____)
- Doctor referral (Name: _____)
- Newspaper, Magazine, etc: Name: _____

I acknowledge that this consultation is for discretionary and elective clinical and non-clinical esthetic procedures and services only, and not for any pathological or dermatological conditions that I may have.

Client Signature Date

Provider Signature Date