229 E. Park Ave
Lake Wales, FL 33853
(863) 232-6968
MM#20448

Name:__________________________ D.O.B:______ Sex: Female__ Male__
Address:__________________________ City:_____________ State:______ Zip_______
Telephone #: Home(___)___________ Cell(___)____________
Employer:______________________Occupation:_____________________
Work #: (___)_______ E-Mail Address:______________________________
In Case of Emergency, Please Notify: Name:_________________________
Relationship:____________________ Telephone:_____________________
Would you like to receive our coupons and special offers by mail or e-mail: Yes__ No__
Please let us know how you heard about us:______________________________________

Please take a moment to carefully read and fill out the following information. If you have a specific medical condition or specific symptoms, some Skin Care may be contraindicated. A referral from your primary care provider may be required prior to receiving therapy.

Have you ever received a professional Facial or Skin Care before: Yes__No__
If yes, when was your last therapy:_______________________
What results would you like to achieve with today's session:_____________
____

Please list any of the following conditions or symptoms that you may have or suffer from:

Yes__ No__ Do you have a pacemaker?
Yes__ No__ Are you pregnant?
Yes__ No__ Are you on the pill?
Yes__ No__ Are you taking any Hormones?
Yes__ No__ Any menopause problems?
Yes__ No__ Are you claustrophobic?
Yes__ No__ Are you wearing contact lenses?
Yes__ No__ Do you have high blood pressure?
If yes, is your blood pressure regulated with medication?
Yes__ No__
Yes__ No__ Do you suffer from epilepsy or seizures?
Yes__ No__ Do you suffer from joint swelling?
Yes__ No__ Do you have any contagious diseases?
Yes__ No__ Do you suffer from stress?
Yes__ No__ Do you have any allergies?
If yes, please list:_____________________________

Yes__ No__ Do you bruise easily?
Yes__ No__ Any injuries in the past two years?
If yes, please explain:______________________________
Yes__ No__ Any broken bones in the past two years?
If yes, where:_____________________________________
Yes__ No__ Do you have cardiac or circulatory problems?
Yes__ No__ Are you ticklish or sensitive to touch?
If yes, please list area(s):___________________________
Yes__ No__ Have you ever had surgery?
If yes, please explain:_____________________________

Please use the area below to list any other medical conditions, or any medications I should know about:
____
____
____

General Skin Care Information

Yes__ No__ Have you ever had skin cancer?
Yes__ No__ Do you use Retin A?
Yes__ No__ Do you use Accutane?
Yes__ No__ Do you use Glycolic Acid products?
Yes__ No__ Have you ever had an Acid Peel?
Yes__ No__ Do you spend a lot of time in the sun?
If yes, do you normally wear sun block?
What SPF do you use:____________________
Yes__ No__ Do you use any home treatment products?
If yes, what Brand do you use:_____________
Yes__ No__ Are you using a harsh exfoliate?
Yes__ No__ Do you use any products containing alcohol?

Yes__ No__ Do you feel any burning or itching of the skin?
If yes, list areas:_____________________________
Yes__ No__ Do you have Rosacea?

Do you think your skin is (Please check all that apply):
Oily__ Dry__ Acne Prone__ Aging__
Normal__ Partly Oily__ Or has Enlarged Pores__

What kind of an improvement would you like to see on your skin:______________________________
____

Signature_________________________ **Date**_________________________

Skin Analysis

(For professionals use only)

Skin Texture: Fine__ Medium Thickness__ Thick__ Very Thick__
Complexion Color: Pale__ Healthy__ Muddy__ Waxy__ Olive__ Sun Tanned__ Burned__
Dehydrated: Superficially__ Deeply__
Gland Secretion: Normal__ Partly Oily__ Oily__ Deeply Oily__ Acne__ Dry__ Very Dry__
Circulation Problems: Couperose__ Rosacea__
Area: Nose__ Cheeks__ Chin__ Forehead__ Entire Face__
Muscle Tone: Good Contour__ Medium Lack of Tone__ Fallen__
Aging Signs: Deep Expression Lines__ Crow’s Feet__ Fine Lines All Over Face__ Falling Eye Lids__

Other Problems:

Scares: Light__ Medium Depth__ Deep__ Areas____
Pigmentation: Light Freckles__ Dark Heavy Freckles__ Pregnancy Mask__ Birthmarks__ Brown Patches__
Double Chin__ Sensitivity to Heat__ Sensitivity to Products______________________________