flirty skin

Name_____Date of Birth_____

Address_____

City_____State_____Zip_____

Telephone ( ) _____Email_____

Occupation_____

How did you hear about us? _____

HEALTH HISTORY (check all that apply)

- □ Accident or Trauma
- □ Allergies (list below)
- □ Anxiety or Nervousness
- □ Arthritis
- □ Asthma
- □ Athlete's Foot
- □ Back Pain
- □ Blood Clots
- □ Bronchitis
- □ Bruise Easily
- □ Cancer
- □ Carpal Tunnel Syndrome
- □ Chronic Fatigue
- □ Constipation
- □ Contact Lens User
- □ Depression
- □ Diabetes
- □ Diverticulitis
- □ Dizziness
- □ Edema
- □ Emphysema
- □ Fibromyalgia
- □ Gastric Reflux
- □ Headaches or Migraines
- □ Heart Conditions
- □ Hearing Impaired
- □ Hepatitis
- □ Hernia
- □ High/Low Blood Pressure
- □ HIV/AIDS
- □ Infectious Diseases
- □ Insomnia
- □ Irritable Bowel Syndrome
- □ Kidney Disease
- □ Menstrual Pain
- □ Muscular Disorders
- □ Neck Pain
- □ Nerve Disorders
- □ Osteoporosis
- □ Pace Maker or Metal Implants
- □ Paralysis
- □ Phlebitis
- □ PMS
- □ Pregnant
- □ Rashes/Skin Conditions
- □ Ruptured Discs
- □ Sciatica
- □ Seizures
- □ Sinus Problems
- □ Skin Cancer
- □ Smoker
- □ Spinal Disorders
- □ Sprains or Strains
- □ Stress (Stress Level 1-10) __
- □ Tendinitis
- □ Thyroid Disorder
- □ TMJ Disorder
- □ Ulcers
- □ Varicose Veins
- □ Other

Allergies_____
List other medical conditions not listed above_____
_____
List any prescriptions, OTC medications and supplements you are currently taking_____
_____

Are you currently under a physician's care? □ Yes □ No
Do you exercise? □ Yes □ No If yes, how many days a week? □ 1-2 □ 3-5 □ 6-7
How many of glasses of water do you consume daily? □ 1-2 □ 3-5 □ 6-8+

Additional Notes:

SKIN CARE

What is your skin type?

□ Normal □ Dry □ Combination □ Oily

What are you currently using on your skin?

□ Cleanser
□ Exfoliant
□ Toner
□ Mask
□ Treatment
□ Eye Cream
□ Serums
□ Day Moisturizer
□ Night Moisturizer
□ Other
□ Sunscreen
□ Makeup

Are you using any of the following?

□ Accutane
□ AHA's/BHA's (Glycolic, Lactic, Salicylic)
□ Retin A/Retinol/Vitamin A
□ Vitamin C Products
□ Birth Control _____
□ Other Topical Medications: _____

What are your primary skin concerns?

□ Acne and/or Acne Scars
□ Blackheads
□ Dark Circles
□ Dry or Flaky Skin
□ Hyperpigmentation (brown spots from sun, scars, hormonal)
□ Hypopigmentation (white spots)
□ Lack of Elasticity and Firmness
□ Rosacea
□ Sun Damage
□ Uneven Tone and Texture
□ Visible Capillaries
□ Whiteheads
□ Wrinkles and/or Fine Lines
□ Other _____

Have you recently had?

□ Botox/Dermal Fillers
□ Chemical Peel
□ Facial
□ IPL/Photofacial
□ Laser Procedures
□ Microdermabrasion
□ Permanent Makeup
□ Plastic Surgery
□ Sunburn or Excess Sun Exposure
□ Tanning Bed Exposure
□ Waxing or Laser Hair Removal
□ Other: _____

How often do you receive facials? □ Never □ Seldom □ Regularly
Do you have a tendency towards redness, rashes or hives? □ Yes □ No
Are you susceptible to Cold Sores or Sun Blisters? □ Yes □ No
Any past product reactions? Explain: _____
_____

I understand that the consultation should not be construed as a substitute for medical examination, diagnosis or medical treatment. I understand that Flirty Skin is not qualified to perform, diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of the consultation given should be construed as such.

Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I agree to keep Flirty Skin updated as to any changes in my medical profile and understand that there shall be no liability on Flirty Skin's part should I fail to do so.

Client Signature _____ Date _____

Flirty Skin _____ Date _____