Essentials for Clear Skin

Specializing in the Treatment of Acne

CLIENT QUESTIONNAIRE

YOUR INFORMATION

Name _____ Age _____DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____Cell Phone _____ Email _____

MEDICATIONS

Medication	When	How Long	Medication	When	How Long
Antibiotics			Androstendione		
Accutane			Testosterone		
Benzoyl Peroxide			Progesterone		
Retin A			Thyroid		
Cream or Gel?			Gonadotrophin		
Tazorac			Danzol		
Differin			Cyclosporin		
Azelex			Lithium		
Avita			Isoniazid		
Cleocin-T			Immuran		
E-mycin-T			Disulfuram		
Copaxone			Dilantin/Tegretol		
Corticosteroids			Steroids		
Quinine			Marijuana		
Other Meds			Cocaine/Speed		

MEDICAL HISTORY – please check all that apply ✓

Herpes Simplex	☐	HIV/AIDS	☐	Hemophilia	☐
Eczema	☐	Thyroid Problems	☐	Lupus	☐
Psoriasis	☐	Hormone Problems	☐	Anemia	☐
Hepatitis	☐	Hysterectomy	☐	High Blood Pressure	☐
Cancer	☐	Ovary(ies) Removed	☐	Diabetes	☐
Staph Infection/MRSA	☐	Pacemaker	☐	Metal Pins in Body	☐

Your primary care physician:

Name: _____ Phone: _____

Are you under a dermatologist's or other skin physician's care? Yes ◯ No ◯

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

1. Have you ever had any reaction to any products or anything you have put on your face? Yes No
   If yes, what products? _____
2. Please check any of these you are allergic to: Sulfur ☐ Aspirin ☐ Latex ☐
   List any other allergies you know of: _____
3. Do you smoke? Yes No
4. Do you use fabric softener or fabric softener sheets in the dryer? Yes No
5. Do you swim in a chlorinated pool? Yes No
6. Do you work around chemicals, tars, oils, grease or inks? Yes No
7. Occupation: _____ Do you work nights? Yes No
8. Are you currently under a lot of stress? Yes No (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)
9. **Women:** Do you use birth control pills, shots or use an IUD? Yes No
   If so, which do you use? _____ What brand of pill? _____
   Are you pregnant or nursing? Yes No
10. **Men:** Do you have shaving irritation? Yes No
    What do you use for shaving? _____

11. Diet – do you consume the following?

Foods	✓	How often per week	Foods	✓	How often per week
Fast Food	☐		Peanuts	☐	
Processed Food	☐		Sushi	☐	
Salty Snacks	☐		Kelp and Seaweed	☐	
Milk/Yogurt	☐		Miso Soup	☐	
Cheese	☐		Soy	☐	
Whey or Soy Protein	☐		Vitamins	☐	
Peanut Butter	☐		Seafood	☐	

PRODUCTS CURRENTLY USING – Provide product names.

Cleanser	
Toner	
Serums	
Moisturizers	
Sun Screen	
Mask	
Foundation	
Blush	
Exfoliant (acids or scrubs)	
Acne Medications	

Anything Else?	

OTHER TREATMENTS: What else have you done for your skin in the last 90 days?

Glycolic/Lactic/Mandelic Peels	When?	Where?
Other Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

How did you hear about us? _____

Essentials for Clear Skin

Specializing in the Treatment of Acne

Client Agreement Form

Please initial the agreements below and sign at the bottom.

1. _____ We *must* adjust your home care routine every two weeks to keep your progress to clear skin moving forward. If we don't change how you do your home care often enough, your skin will adapt to the regimen and stop responding (in other words, you won't get clear). I agree to contact my skincare professional so we can adjust your home care regimen at least every two weeks.

2. _____ Each time we strengthen your home care, we run the risk of drying and irritating your skin, so you will need to communicate that to us if that happens. I agree to contact my skincare professional if my skin gets uncomfortably dry and irritated.

3. _____ I will not use any other products that have not been approved by my skincare professional while I am on their regimen.

4. _____ I will not change the regimen given to me by my skincare professional without notifying or consulting with them first.

5. _____ I will not run out of product while working with my skincare professional. When you stop using products (or run out) acne will start forming inside the pores and you will see it about a month later.

6. _____ I will not have other skin care treatments while I am being treated by my skincare professional.

7. _____ I will inform my skincare professional of any medications/drugs that I start taking while using their regimen.

8. _____ I will use my sunscreen every morning, regardless of whether or not I will be going outside. The sunscreen will help to keep your skin moisturized. Without it, your skin will get too dry.

9. _____ I will not get sunburned or wind burned while being treated by my skincare professional. (You will not be able to use your active products; and we will not be able to do treatments on you.)

10. _____ I will inform my skincare professional if I elect to do any laser treatments or waxing for hair removal.

11. _____ (For women) - I will inform my skincare professional if I get pregnant.

12. _____ **MOST IMPORTANTLY**: If we are unable to improve the condition of your skin due to factors beyond our control, *but within yours*, we reserve the right to decline treatments. (That is, if you are not following our instructions pertaining to home care, doing your home care, lifestyle issues, etc.)

I, _____, hereby agree to all of the above.

Date _____

Essentials for Clear Skin

Specializing in the Treatment of Acne

ACNE TREATMENT CONSENT FORM

An acne treatment may consist of surface cleansing, mild chemical peels or steam and exfoliation, application of antibacterial serums, corrective serums and extractions. Treatments take approximately 20 to 45 minutes to complete and are designed to balance, hydrate, clear acne impactions and prepare the skin for the home care regimen. Implements and equipment used in all this facility are disposable or properly sterilized according to the State Board of Cosmetology regulations.

IMPORTANT: PLEASE READ CAREFULLY and initial

_____I have not been exposed to excessive sun and my skin does not feel sensitive or irritated in any way.
_____I have not had any other chemical peel of any kind, within 14 days of this treatment.
_____ I have not had any facial waxing, within seven days of this treatment.
_____I have informed the clinic of all health problems of which I am aware, including herpes simplex/cold sores.
_____I have informed the clinic of any use of oral or topical medications I may be using including Retinoids (Retin-A, Renova, Avita, Differin, Tazorac) or Accutane.
_____I understand that controlling acne/problem skin is best achieved through a series of recommended treatments and compliance to the home care product program recommended by a Face Reality certified esthetician.
_____I understand that I will probably not experience much visible peeling, flaking, discoloration or irritation following this procedure if I follow my homecare instructions carefully.

WARNINGS: PLEASE READ CAREFULLY and initial

_____Avoid direct sunlight or tanning booths for at least three days following a treatment.
_____Use of sunblock protection of at least a SPF 30 is necessary following all treatments.
_____Do not pick your skin following a treatment.

PRODUCT RETURN GUIDELINES: PLEASE READ CAREFULLY and initial

_____Face Reality Skin Care products are clinical-strength active formulas designed to treat problem skin conditions. Tingling sensations are normal with product application but should not be painful. If you are experiencing stinging and irritation with any product, stop using the product and call your esthetician for further instruction.
_____Products may be returned within 30 days for a full refund, provided they have not been opened and/or used. If products have been opened or used it is mandatory to speak with an esthetician to obtain authorization to return that product.

RESCHEDULING GUIDELINES AND LATE POLICY: PLEASE READ CAREFULLY and initial

_____A 24-hour rescheduling notice is required. We realize emergencies happen and will be considered, but reserve the right to charge a $50.00 fee for missed appointments without a 24-hour notice. If you are more than 20 minutes late we cannot guarantee that we will be able to fit your appointment into the schedule and you may not be seen. If we cannot fit you in there will be a $50 fee charged for the missed appointment.

I, _____, consent to photographs taken of my face to be used for monitoring treatment progress.

I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-treatment care instructions as I am directed.

Name: _____ Date:_____

Address: _____ City: _____State: ____ Zip: _____

Signature of Client: _____

Signature of Esthetician: _____

These documents are necessary for treatment. The submit link to Essentials for Clear Skin is ONLY compatible with the browser Internet Explorer. In addition clients may need to sign the documents in person on location. If Internet Explorer is not an option then save this file to your computer, create an email and send as an attachment to info@essentialsforclearskin.com

Submit