Spa Saturday
Have a little "Me" time

PERSONAL DATA - Please Print Clearly

Date:_____

Name: _____ Referred By_____

Address: _____ Home Phone: _____

City, State, ZIP: _____ Work Phone: _____

Birth date: _____ Email address: _____

Your Health
1. Within the last year, have you been under a physician's care?   _ yes _ no
2. Within the last year, have you been under a dermatologist's care?   _ yes _ no
3. Within the last nine months, have you undergone any surgery?   _ yes _ no

    If yes, please specify_____

4. Have you had any of these health problems in the past or present?
    _ cancer _ diabetes _ epilepsy _ heart problem _ hormone imbalance _ spinal injury

    _ hysterectomy_ thyroid condition _ varicose veins _ systemic diseases

5. List any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly
6. Do you smoke?   _ yes _ no
7. Do you exercise regularly?   _ yes _ no
8. Do you follow a restricted diet?   _ yes _ no
9. Do you have regular sleep patterns?   _ yes _ no
10. Do you wear contact lenses?   _ yes _ no
11. Do you have metal implants or a pacemaker? _ yes _ no

Your Skin

12. With what temperature water do you cleanse? _ cool _ warm _ hot
13. Do you have any special skin problems pertaining to your face or body? _ yes _ no
     If yes, please specify _____
14. What skin care products are you currently using?
     _ soap _ cleanser _ toner _ moisturizer _ masque _ exfoliator _ eye products _
     others _____

Exfoliation History

15. Have you ever had chemical peels, laser, microdermabrasion treatments?_ yes _ no
in the last month? _ yes _ no

16. Do you use Accutane, Retin A, Renova or Adapalene?_ yes_ no
in the last 3 months? _ yes_ no

17. Do you use an acne medication?_ yes_ no
in the last 6 months? _ yes _ no
     If yes, which drug?_____

18. Are you currently using any products that contain the following ingredients?
     _ glycolic acid _ lactic acid _ any exfoliating scrubs
     _ any hydroxy acid product _ vitamin A derivatives such as retinol?

Moisture Hydration

19. How much plain water do you consume daily? _____
20. How many alcoholic beverages do you consume weekly? _____
21. Do you ever experience these conditions on your skin? _ flakiness _ tightness _ obvious dryness
22. What spf sunscreen do you use on your face? _____ Body? _____
23. Do you sunbathe or use tanning beds _ yes _ no

Capillary Activity

24. Do you burn easily in moderate sunlight? _ yes _ no
25. Do you blush easily when nervous? _ yes _ no
26. Do you have a tendency to redness? _ yes _ no
27. Do you suffer from sinus problems? _ yes _ no

Oil Secretion

28. Do you ever experience oily shine during the day? _ yes _ no _ occasionally
29. Do you ever experience skin breakouts? _ yes _ no _ occasionally

Nerve Activity

30. Do you drink caffeinated beverages (coffee, tea, softdrinks)? _ yes _ no
     How many daily? _____
31. Do you ever experience a burning, itching sensation on your skin? _ yes _ no
32. What is your pain threshold? _ low _ medium _ high
33. Have you ever experienced claustrophobia? _ yes _ no
34. What type of massage pressure do you prefer? _ soft _ medium _ firm

35. Have you ever had a reaction to any of the following?

_ cosmetics _ medicine _ iodine _ pollen _ food _ hydroxy acids _ animals _ fragrance _ sunscreens

_ other _____

Female Clients Only

36. Are you taking oral contraception?   _ yes _ no
37. Are you pregnant or trying to become pregnant?   _ yes _ no
38. Are you lactating?   _ yes _ no

Male Clients Only

39. What is your current shaving system?   _ electric   _ wet shave
40. Do you experience irritation from shaving? _ yes _ no
41. Do you experience ingrown hairs?   _ yes _ no

Questions to discuss every visit

42. are you currently having or due for your menstrual cycle? _ yes _ no
43. Have you started any new medication?   _ yes _ no
44. Have you had any recent dental x-rays?   _ yes _ no

45. What are your skin care goals?_____

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any in-

formation that may be relevant to my treatment.

_____

Client Print

_____
Client signature   date

_____

_____
Spa Saturday Representative: date

_____