HOLISTIC HARMONY
5780 YORK ROAD
NEW OXFORD PA 17350

CLIENT CONSULTATION/INTAKE FORM (FACIALS)

NAME_____ DATE OF BIRTH_____

SEX: FEMALE_____ MALE_____

HOW WERE YOU REFERRED TO US? _____
OCCUPATION: _____ DOES YOUR JOB REQUIRE THAT YOU WORK OUTDOORS? _____
WHAT WOULD YOU LIKE TO ACHIEVE FROM YOUR TREATMENT TODAY? _____

YOUR SKIN CARE

1) HAVE YOU EVER HAD A FACIAL TREATMENT BEFORE? _____ WHEN? _____
2) HAVE YOU EVER HAD A BODY SPA TREATMENT BEFORE? _____

   IF YES, PLEASE SPECIFY WHEN AND WHAT TREATMENT: _____

3) WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE: (PLEASE CIRCLE ONE)
   - TYPE I FAIR SKIN TONES - ALWAYS BURNS, NEVER TANS
   - TYPE II LIGHT SKIN TONES - BURNS EASILY, TANS SLIGHTLY
   - TYPE III FAIR TO OLIVE SKIN TONES - BURNS MODERATELY, TANS MODERATELY
   - TYPE IV LIGHT BROWN SKIN TONES – BURNS SLIGHTLY, TANS EASILY
   - TYPE V DARK BROWN SKIN TONES – RARELY BURNS, TANS EASILY
   - TYPE VI DARK BROWN TO BLACK SKIN TONES – NEVER BURNS, TANS EASILY
4) DO YOU HAVE ANY SPECIAL SKIN PROBLEMS OR CONCERNS PERTAINING TO YOUR FACE OR BODY? _____
   IF YES, PLEASE SPECIFY: _____
5) HAVE YOU EVER HAD CHEMICAL PEELS, LASER TREATMENTS OR MICRODERMABRASIONS? _____
   IN THE LAST MONTH? _____
6) DO YOU USE ACCUTANE, RETIN-A, RENOVA, ADAPALENE HYDROXYL ACID OR ANY OTHER RETINOL/VITAMIN A DERIVATIVE PRODUCTS? _____
7) HAVE YOU USED ACNE MEDICATION? _____ WHEN? _____ WHICH MEDICATION? _____
8) HAVE YOU EXPERIENCED BOTOX, RESTYLANE OR COLLAGEN INJECTIONS? _____
   IF YES, PLEASE SPECIFY: _____
9) WHAT SKIN CARE PRODUCTS ARE YOU CURRENTLY USING? (LIST BRANDS IF KNOWN)

   CLEANSER_____TONER_____

   DAY MOISTURIZER_____NIGHT MOISTURIZER_____

   EXFOLIATOR_____MASK_____

   EYE PRODUCT _____ SPF/SUNSCREEN_____

   SCRUBS_____MAKEUP PRODUCTS_____

   SOAP_____SHOWER GELS_____

   BODY LOTIONS_____ OTHER_____

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10) HAVE YOU USED ANY HAIR REMOVAL METHODS IN THE PAST SIX WEEKS? _____ (CHECK ALL THAT APPLY)

☐Shaving ☐Waxing ☐Electrolysis ☐Plucking ☐Tweezing ☐Stringing

☐Depilatories ☐Other: _____

11) WHAT AREAS OF CONCERN DO YOU HAVE REGARDING YOUR:

SKIN (CHECK ALL THAT APPLY):

☐Breakouts/acne ☐Uneven skin tone ☐ Blackheads/whiteheads ☐ Sun damage ☐ Excessive oil/shine

☐Wrinkles/fine lines ☐ Rosacea ☐Dull/dry skin ☐ Broken capillaries ☐ Flaky skin ☐Redness/ruddiness

☐Dehydrated ☐Sun/liver/brown spots ☐Other: _____

EYES (CHECK ALL THAT APPLY):

☐Dehydrated ☐Wrinkles ☐ Puffiness ☐Dark circles ☐ Other: _____

LIPS (CHECK ALL THAT APPLY):

☐Dehydrated ☐Cracked/chapped lips ☐Other: _____

12) HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING (CHECK ALL THAT APPLY)

☐Cosmetics ☐AHAs ☐ Medication ☐ Fragrance ☐Food ☐ Shellfish ☐Animals

☐Latex ☐Sunscreens ☐Drugs ☐ Iodine ☐ Pollen ☐Other: _____

If yes, please specify: _____

13) WHAT SPF DO YOU USE ON YOUR FACE? _____HOW OFTEN/WHEN? _____

14) HAVE YOU RECENTLY USED ANY SELF-TANNING LOTIONS, CREAMS OR TREATMENTS? _____

If yes, please specify: _____

15) HAVE YOU HAD ANY RECENT TANNING BED OR SUN EXPOSURE THAT CHANGED THE COLOR OF YOUR SKIN? _____

If yes, please specify: _____

HEALTH HISTORY

DO YOU HAVE ANY ALLERGIES? (If so please list) _____

PLEASE LIST ALL MEDICATIONS, SUPPLEMENTS OR PRESCRIPTIONS THAT YOU ARE CURRENTLY TAKING (ORALLY OR TOPICALLY):

_____

_____

_____

_____

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LIFESTYLE

16) HOW MANY GLASSES OF WATER DO YOU DRINK PER DAY?

☐<1 Glass ☐ 1-3 Glasses ☐ 4-7 Glasses ☐8+ Glasses

17) HOW MANY CAFFEINATED BEVERAGES (Coffee, Tea, Soda, Etc.) DO YOU CONSUME PER DAY?

☐None ☐1-2 Drinks ☐3-5 Drinks ☐6+ Drinks

18) HOW MANY ALCOHOLIC BEVERAGES DO YOU CONSUME PER WEEK?

☐I don't drink ☐1-3 Drinks ☐ 4-7 Drinks ☐ 8+ Drinks

19) HOW MANY HOURS OF SLEEP DO YOU GET PER NIGHT?

☐<3 hours ☐ 3-5 Hours ☐ 6-8 Hours ☐ 8-10 Hours ☐10+ Hours

20) WHICH FOODS DO YOU CONSUME ON A REGULAR BASIS?

☐Fruits ☐Vegetables ☐Dairy/Eggs ☐Cheese ☐ Poultry ☐ Fish ☐Grains/Bread
☐Processed Sugar ☐ Processed Meats

21) HOW MANY HOURS DO YOU SPEND IN FRONT OF A SCREEN OR DIGITAL DEVICE?

☐<3 Hours ☐ 4-6 Hours ☐7-9 Hours ☐10-12 Hours ☐12+ Hours

22) DO YOU EXERCISE ON A REGULAR BASIS? ☐Yes ☐No

23) DO YOU SMOKE CIGARETTES, VAPE OR CONSUME OTHER TOBACCO PRODUCTS? ☐Yes ☐No

24) WHAT ARE YOUR STRESS LEVELS ON A SCALE FROM 1 TO 5 (1=low stress, 5=high stress)? _____

FEMALE CLIENTS

25) ARE YOU TAKING ORAL CONTRACEPTIVES? ☐Yes ☐No (Please specify type):_____

26) ANY RECENT CHANGES TO OR FROM YOUR CONTRACEPTIVE TREATMENTS? ☐Yes ☐No

If Yes, please specify what and when: _____

27) ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? ☐Yes ☐No

28) ARE YOU EXPERIENCING ANY MENOPAUSAL SYMPTOMS? ☐Yes ☐No

If yes, please specify: _____

29) ARE YOU UNDERGOING ANY HORMONE REPLACEMENT THERAPY TREATMENTS? ☐Yes ☐No

If yes, please specify:_____

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MALE CLIENTS

30) DO YOU EXPERIENCE IRRITATION FROM SHAVING? ☐Yes ☐No

If yes, please specify: _____

31) DO YOU EXPERIENCE INGROWN HAIRS AS A RESULT OF HAIR REMOVAL ☐Yes ☐No

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

CLIENT NAME (PRINTED):_____

CLIENT NAME (SIGNATURE):_____ DATE:_____