

# Skinology Skincare's Client Health Questionnaire

Date / /

9159 W 133<sup>rd</sup> street, Overland Park, KS 66213 # 913.239.8501

## Client Information:

Name \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Single \_\_\_ Married \_\_\_ Spouse's Name \_\_\_\_\_ Children's Name \_\_\_\_\_  
Date of birth \_\_\_/\_\_\_/\_\_\_ Occupation \_\_\_\_\_  
Referred by \_\_\_\_\_  
Additional Information \_\_\_\_\_

## Medical Information: check all that apply

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Pregnant                                | <input type="checkbox"/> Birth Control       | <input type="checkbox"/> Hormone Replacement | <input type="checkbox"/> Smoker                              |
| <input type="checkbox"/> Oral Antibiotic                         | <input type="checkbox"/> Topical Antibiotic  | <input type="checkbox"/> Steroids            | <input type="checkbox"/> Asthma                              |
| <input type="checkbox"/> Neck / Back Pain                        | <input type="checkbox"/> Headaches           | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Seasonal Allergies                  |
| <input type="checkbox"/> Latex Allergy                           | <input type="checkbox"/> Peanut Allergy      | <input type="checkbox"/> Iodine Allergy      | <input type="checkbox"/> Aspirin Allergy                     |
| <input type="checkbox"/> Hypertension*                           | <input type="checkbox"/> Heart Disease**     | <input type="checkbox"/> Pacemaker**         | <input type="checkbox"/> Metal Plates, Pins, or Prosthetics  |
| <input type="checkbox"/> Diabetic                                | <input type="checkbox"/> Prone to Cold Sores | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Herpes                              |
| <input type="checkbox"/> Rashes/ Hives                           | <input type="checkbox"/> Shingles            | <input type="checkbox"/> Bursitis            | <input type="checkbox"/> Skin Cancer                         |
| <input type="checkbox"/> Rosacea                                 | <input type="checkbox"/> Use Retinol         | <input type="checkbox"/> Use Tazorac         | <input type="checkbox"/> Use Accutane: last used ___/___/___ |
| <input type="checkbox"/> Currently under physician's Care: _____ |  |  |  |

## Daily Home Regimen: check all that apply

- |  |   |                                      |  |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Facial Soap     | <input type="checkbox"/> Facial Cleanser          | <input type="checkbox"/> Toner       | <input type="checkbox"/> Moisturizer       |
| <input type="checkbox"/> Masque          | <input type="checkbox"/> Exfoliator / Scrubs      | <input type="checkbox"/> Eye Product | Brands _____                               |
| <input type="checkbox"/> Sunscreen Daily | <input type="checkbox"/> Sunscreen Recreationally |                                      | <input type="checkbox"/> Tan/ Tanning Beds |
- Are you currently using any products that contain the following ingredients?
- |  |                                      |                                       |  |
|--|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Glycolic Acid | <input type="checkbox"/> Lactic acid | <input type="checkbox"/> Hydroxy Acid | <input type="checkbox"/> Vitamin A Derivatives |
|--|--------------------------------------|---------------------------------------|--|

## Skin Concerns: check all that apply

- |  |                                     |   |                                       |
|--|-------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Premature Aging | <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Wrinkles           | <input type="checkbox"/> Texture/Tone |
| <input type="checkbox"/> Pigmentation    | <input type="checkbox"/> Acne       | <input type="checkbox"/> Flushing / Redness | <input type="checkbox"/> Pore Size    |

## When you go out into the sun do you:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Always Burn (I)      | <input type="checkbox"/> Usually Burn (II) |   |   |
| <input type="checkbox"/> Sometimes Burn (III) | <input type="checkbox"/> Rarely Burn (IV)  | <input type="checkbox"/> Very Rarely Burn (V) | <input type="checkbox"/> Never Burns (VI) |

I understand that the use of certain medications and over the counter products can significantly increase the risk of adverse reactions and/or injury. I hereby confirm that I am not using any medication that may cause or contribute to any such reaction/injury and I will advise my therapist should I be using any such medication in the future. I understand that there are inherent risks associated with skincare services, and I agree that as a condition of providing these services on an ongoing basis, I will not hold responsible anyone at **Skinology Skincare, LLC** should there be any unfavorable outcome or result.

Client Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_



# *Skinology Skincare's* Client Consent to Treatment

9159 W 133<sup>rd</sup> Street, Overland Park, KS #913.239.8501

## Client Copy

My signature acknowledges that I have read and agree to receive the following treatments or series of treatments. I, \_\_\_\_\_ consent to and authorize **Skinology Skincare, LLC** to perform facials, skin exfoliation, chemical peels, microdermabrasion, micro current, skin waxing and other related skin care services.

- **I have not used Accutane for at least 12 months.** \_\_\_\_\_(Initial)
- **I have not used a scrub, Retin-A, Tazorac, take home microdermabrasion, glycolic peels or other types of exfoliates in the last 72 hours.** \_\_\_\_\_(Initial)
- I have no allergies to Iodine (seaweed/algae based). \_\_\_\_\_(Initial)
- I have no allergies to peanuts. \_\_\_\_\_(Initial)
- I have no allergies to aspirin. \_\_\_\_\_(Initial)
- I am not Epileptic and do not have heart or circulation problems. \_\_\_\_\_(Initial)
- **Possible side effects** from microdermabrasion, chemical peels, and micro currents, but are not limited to: mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. **Most side effects are temporary and generally fade within 72 hours.** \_\_\_\_\_(Initial)
- **Waxing may cause:** bruises, scabs, scarring, redness, hyper pigmentation or pimples. Waxing of soft tissue may cause the skin to tear resulting in the need for stitches (Brazilian/Bikini). \_\_\_\_\_(Initial)
- I agree not to pick, peel, or scratch the skin during the healing phase, as this may cause undesirable side effects or results. \_\_\_\_\_(Initial)
- **It is recommended to discontinue use of all AHA's, Glycolic, Retin-A, Renova, or any exfoliation products up to 72 hours post procedure.** \_\_\_\_\_(Initial)
- **I agree to use Image Post-Treatment Kits as directed or products in the Vital-C or OrMedic Skincare line and Solar Defense daily.** \_\_\_\_\_(Initial)
- **Use hydrocortisone crème twice a day as needed** with a cold compress for swelling and inflammation reduction. \_\_\_\_\_(Initial)
- **Use Vanish PFB twice a day** for a week after any wax services to prevent ingrown hairs and break outs; and use as needed after. \_\_\_\_\_(Initial)
- After treatments **avoid, direct sun exposure, tanning beds, pools, hot tubs, saunas, waxing, and additional professional treatments for 72 hours.** \_\_\_\_\_(Initial)
- If I have Herpes or MRSA I may experience an outbreak and I understand I may carry Herpes and/or MRSA without any physical symptoms or having had a medical diagnosis confirmed. \_\_\_\_\_(Initial)
- If prone to cold sores see your physician about a prescription for Aycloovair, Zovirax, or take supplements of Olive Leaf, L-Lysine along with Beta Carotene, and Folic Acid daily. \_\_\_\_\_(Initial)
- The nature and purpose of the treatments have been explained to me, and any questions I may have regarding this procedure have been explained to my satisfaction. \_\_\_\_\_(Initial)
- I understand that with any treatment certain risks are involved and that any complications or side effects from known or un-known causes could occur. I freely assume these risks. \_\_\_\_\_(Initial)

*Client Signature* \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_