

Body RESTORATION[®] Skin Care Profile

Name _____ Address _____

City _____ State _____ Zip _____ Date of Birth _____

Email: _____ Phone(Day) _____ (Night) _____

Profession _____ How did you hear about us? _____

Your Health

1. Within the last year, have you been under a dermatologist or other physician's care?
Yes/No
2. Within the last nine months, have you undergone any surgery? Yes/No
If yes, please specify _____
3. Have you had any health problems in the past or present? Yes/No
If yes, please specify _____
4. List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly _____
5. Do you smoke? Yes/No
6. Do you exercise regularly? Yes/No
7. Do you follow a restricted diet? Yes/No
8. Do you wear contact lenses? Yes/No
9. Do you have metal implants, a pacemaker or body piercings? Yes/No
10. Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress): ____

Your Skin

11. Do you have any special skin problems pertaining to your face or body?
If yes, please specify _____
12. What skin care products are you currently using?
Face: _ Soap _ Cleanser _ Toner _ Moisturizer _ Masque _ Exfoliator _ Eye Products
Body: _ Soap _ Shower gel _ Scrubs_ Oil _ Body Moisturizer _ Depilatory Products
_ Self Tanners

Exfoliation History

13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?
Yes/No ... in the last month? Yes/No
14. Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? Yes/No ... in the last 3 months? Yes/No
15. 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 (i.e. Retinol)

Moisture Hydration

16. How much plain water do you consume daily? ____
17. How many alcoholic beverages do you consume weekly? ____
18. Do you ever experience these conditions on your skin?
_Flakiness _Tightness _Obvious dryness
19. What SPF sunscreen do you use on your face? ____ Body? ____
20. Do you sunbathe or use tanning beds? Yes/No/Occasionally

Capillary Activity

21. Do you burn easily in moderate sunlight? Yes/No/Occasionally
22. Do you blush easily when nervous? Yes/No/Occasionally
23. Do you have a tendency to redness? Yes/No/Occasionally
24. Do you suffer from sinus problems? Yes/No/Occasionally

Oil Secretion

25. Do you ever experience oily shine during the day? Yes/No/Occasionally
26. If yes, what time of day are you noticing a shine on your face? _____
27. Do you ever have skin breakouts? Yes/No/Occasionally

Nerve Activity

28. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) ____
29. Do you ever experience a burning, itching sensation on your skin? Yes/No/Occasionally
30. What is your pain threshold? Low/Medium/High
31. Have you ever experienced Claustrophobia? Yes/No/Occasionally
32. What type of massage do you prefer? Light/Medium/Firm
33. Have you ever had a reaction to the following?
_Cosmetics _Medicine _Iodine _Pollen _Food _ Hydroxy Acids _Animals _Fragrance
_Sunscreens _Other (specify) _____

Female clients only

34. Are you taking oral contraception? Yes/No
35. Are you pregnant or trying to become pregnant? Yes/No
36. Are you lactating? Yes/No
37. Are you currently having or due for your menstrual period? Yes/No

Male Clients only

38. What is your current shaving system? Electric/Wet Shave
39. Do you ever experience irritation from shaving? Yes/No
40. Do you experience ingrown hairs? Yes/No

Questions to discuss every Visit

41. Have you started any new medication since your last visit? Yes/No
If yes, please specify _____
42. Have you had any recent dental x-rays? Yes/No
43. 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 information that may be relevant to my treatment.

Signature _____ Date _____