

Client Name: _____

Date: _____

CLIENT LASER/COSMETIC INTAKE

SKIN CARE HISTORY

List the type and brand of skin care products that you currently use: _____

Have you had an allergic reaction to any product? YES/NO

If yes, please explain which product and what type of reaction you had. _____

Do you tan regularly? YES/NO Do you use tanning products? YES/NO

Do you use sun protection? YES/NO SPF# _____

Do you smoke? YES/NO Do you drink alcohol? YES/NO How often? _____

Do you drink Caffeine? YES/NO How often? _____

How many glasses of water do you drink each day? _____

HISTORY OF PROCEDURES

Please check any procedures that you are currently receiving or have previously experienced.

Botox

Body Scrub/Wrap

Chemical Peels

Chiropractic Adjustment

Cosmetic Surgery

Dermabrasion

Face Lift

Laser Resurfacing

Lipodissolve

Massage

Manicure/Pedicure

Mesotherapy

Physical Therapy

Restylane (or other injectable filler)

Have you had any adverse reactions to any of these procedures or treatments? YES/NO

If yes, please explain in detail. _____

INFORMATION SPECIFIC TO TODAY'S VISIT

What result do you expect from your visit today? _____
