SOUL SERENITY, LLC
SKINCARE · REIKI · MEDITATION

Date _____

Name _____ Date of Birth _____

Address _____

Home Phone _____ Business Phone _____

Cell Phone _____ Email Address _____

Your Skin

Do you wear sunscreen daily? _____ What Brand/SPF? _____

What do you wish to achieve from your treatment today? _____

What is your long term skin goal? _____

Have you ever had a facial treatment? Yes/No What type of treatment? _____

Have you ever had a reaction to any skin care treatment and/or product? Yes/No

specify _____

Do you have any special skin problems or concerns pertaining to your face or body? Yes/No

specify _____

Have you ever had chemical peels, microdermabrasion, galvanic, ultrasonic, led or high frequency treatments? Yes/No

specify _____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? Yes/No

specify _____

Do you use any acne medications? Yes/No

specify _____

What skin care products do you currently use? _____

What is your current skin care routine? _____

Have you been in the sun or used tanning beds in the past 2 weeks? Yes/No

Have you used sunless/self tanning lotions in the past 2 weeks? Yes/No

Do you plan on being in the sun/tanning bed in the following week? Yes/No

What hair removal methods have you used in the past two weeks? _____

Have you experienced Botox, Restylane or Collagen injections? Yes/No

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What areas of concern do you have regarding your: **Skin**: (Please check any that apply and explain)

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 Skin ☐

Sun Spot/Liver Spot/Brown Spot ☐ Other _____

Eyes :

Dehydrated ☐ Wrinkles ☐ Puffiness ☐ Dark Circles ☐ Other _____

Lips :

Dehydrated ☐ Cracked/Chapped ☐

Have you ever had an allergic reaction to any of the following? (Please check any that apply) If yes, please explain:
_____

Cosmetics ☐ AHA's ☐

Medicine ☐ Fragrance ☐

Food ☐ Shellfish ☐

Animals ☐ Latex ☐

Sunscreens ☐ Drugs ☐

Iodine ☐ Other _____

Pollen ☐

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Female Clients Only:

Are you taking oral contraceptives? Yes/No

specify: _____

Any recent changes to or from your contraceptive treatment? Yes/No

If so, what and when: _____

Are you pregnant or trying to become pregnant? Yes/No

Are you lactating? Yes/No

Any menopause problems? Yes/No

specify: _____

Are you undergoing any hormone replacement therapy? Yes/No

specify: _____

Male Clients Only:

What is your current shaving system? Wet shave □ Electric □

Do you experience irritation from shaving? Yes/No Ingrown hairs? Yes/No

Please use this space to complete answers where space was insufficient.

_____
_____
_____

Future Appointments/Contact: May I call you at your home, work or cell phone number to confirm appointments? Yes/No

May I contact you via mail/email about future promotions and news? 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 skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date:_____