Skin Rejuvenation Clinic

Client Intake Questionnaire

Personal Information

Last Name_____ **First**_____ **MI**_____ **DOB**_____/_____/_____ **Age**_____ ☐ M ☐ F
Address_____
City_____ State_____ Zip_____
Main Tel_____☐ Cell ☐ Home ☐ Work Secondary Tel_____☐ Cell ☐ Home ☐ Work
I would like to receive appt. communications via: ☐ Email ☐ Text ☐ Phone ☐ I do **NOT** wish to receive appointment communications
I give my consent for the clinic to leave a message via (check all that apply): ☐Email ☐Text ☐Phone ☐Do not leave any messages
Email address_____
☐ It is **not** ok to send a monthly e-newsletter with sales/specials via email. (*We do not sell, share or spam any information you provide. Our email correspondence is kept to a minimum.*)

Marital Status: ____Single ____Married ____Divorced ____Widowed ____Separated # of Children:_____

Work Status: ____Full-Time ____Part-Time ____Self-Employed ____Homemaker _____Retired _____Unemployed _____Student

Occupation: _____

Emergency Contact_____ **Contact Phone**_____

From whom or how did you first hear about Skin Rejuvenation Clinic? ("X" box and fill in field if known)

	Radio ad – name of station:		Internet – name of website:
	Magazine – name of magazine:		Skin Rejuvenation Clinic website
	Newspaper – name of newspaper:		Friend or family member – name
	TV- name of station or show:		Business/Organization—name of business/org:
	Walk-in/Drive By		Other – please specify:

Skin Care Information

What is the main reason you came in for today's consultation or initial visit?_____
What conditions would you like to improve? ("x" all that apply)

Aging		***Pigment***		***Skin Care/General***		***Other***
	Smokers lines, vertical lines above lip		Rosacea, redness		Acne scarring		Unwanted fat – area:
	Nose –to-mouth lines		Freckles		Oiliness		Unwanted hair- area:
	Fine lines and wrinkles		Broken capillaries		Dryness and/or flakiness		Nose shape or bump
	Corner-of-mouth lines		Age, sun or brown spots		Pore size		Elimination of large pimple/zit
	Sunken cheeks		Dark circles under eyes		Acne		Excessive sweating (underarms, hands)
	Crow's feet		Scar(s)		Facial "fuzz" or facial hair		Uneven or sparse brows
	Frown lines (b/t brows)		Unwanted mole(s)		Skin texture (crepiness)		Short and/or sparse eyelashes
	Aging hands		Melasma (Pregnancy mask)		Dull skin tone		Vaginal Tightness and /or Lubrication
	Mouth-to-chin lines		Spider veins-- location:		Thin or uneven lips		Leaky bladder
	Forehead lines		Uneven skin tone		Loose, sagging skin- area:		Other – please specify
	Other – please specify		Other—please specify:		Other—please specify:		

Have you been diagnosed with any skin conditions? No Yes If yes, please specify_____

What skin care products do you frequently use?

AM **PM**

_____ _____
_____ _____
_____ _____

Are you able to change your skin care regimen? No Yes

Are you taking any vitamins? No Yes -- If yes, please list_____
_____

(Continued on reverse side page)

Do you use any of the following products?

	Retin A or Retinol		Glycolic acid
	Hydroquinone		Salicylic acid
	Accutane		Other, please specify:

If you have had any reactions to any of the above products, please explain:_____
_____

Have you ever had any of the following treatments? ("x" all that apply)

	Body contouring procedure		Chemical peel		Fillers (Restylane, collagen, Juvederm…)
	Laser vein treatment		Botox		Laser Peel
	BBL/IPL		Microdermabrasion		Laser Hair Removal
	Acne treatment, please specify:		Plastic surgery, please specify:		Other:

Medical Information

Are you seeing any doctor, for any reason? No Yes --If yes, reason:_____

Do you have, or have you had any of the following conditions? ("x" all that apply)

	Acne		Warts		Diabetes
	Skin cancer		Multiple Sclerosis		Migraines
	Keloid scarring		Epilepsy		Autoimmune system disorder
	Dermatitis		High or low blood pressure		Staph infection
	Acne scarring		Chest pain		Easy bruisability
	Cold sores		Heart attack		Depression
	Cancer— list type:		Shortness of breath		Stomach problems
	Eczema		Hepatitis		Allergies to strawberries
	Active rosacea		Asthma		Undiagnosed lesions
	Thyroid Disorder		Leaky Bladder		Painful Intercourse
			Other:		Other:

Please list all medications and vitamins you take:_____
_____
_____

Please list any allergies you may have, including allergies to medications and soy:_____
_____

Please list all surgeries and approximate dates, including cosmetic:_____
_____

Are you pregnant or planning to be? No Yes

Do you ever tan in tanning beds? No Yes

Do you smoke? No Yes

Are you able to wear sun protection everyday? No Yes

Comments or questions:
_____
_____
_____

I, _____ do fully understand all of the questions above and have answered them all correctly and honestly. By signing below I release Skin Rejuvenation Clinic, P.A. and its employees from all liability.

Signed by client _____ Date_____

Signed by skin care professional_____ Date_____