Inner Beauty
SKIN CARE

122 N. 4th Street - Suite 2010
Lake Mary, FL 32746
www.innerbeautysc.com

PERSONAL INFORMATION

First Name: ___________________ Last Name: ___________________ Today's Date: _____/______/_____

Address: ____ Date of Birth: ____/______/_____

City: _________________________ State:________________________ Zip: ________________________

Phone:_______________________ E-mail:_______________________ Occupation:_________________

How do you agree to receive communication? (check which apply) ____ E-mail _____ Text

Which social media outlets are you on? ___ Facebook ___Instagram ___ Twitter ___ LinkedIn ___ Pinterest

Who referred you to our clinic? ____

Have you ever had a facial treatment before? (*If yes, when & what type*) __________________________________

Do you have any allergies to any foods, fruits, medications or other topical agents? ____ Yes ____ No

If yes, what type? ____

List all medications including prescriptions, over-the-counter or supplements (multivitamin, herbal, etc.)

____

____

What would you like to change regarding your skin?

____

____

SKIN HISTORY

Have you undergone any of the following in the last 2-6 months? (Check all that apply)

_____ Laser	_____ Microdermabrasion	_____ Chemical Peels	_____ Cosmetic Surgery
_____ Facial Surgery	_____ Facial Waxing	_____ Botox	_____ Collagen Injections

If yes, when & where on your body? ____

How would you describe your skin? (Check all that apply)

_____ Mature	_____ Flaky	_____ Red	_____ Uneven Texture
_____ Rough	_____ Acne	_____ Large Pores	_____ Normal
_____ Dry	_____ Combination	_____ Sensitive	_____ Oily
_____ Sun Damaged	_____ Dark Circles	_____ Acne Scars	_____ Under Eye Puffiness
_____ Wrinkles	_____ Crows Feet	_____ Discoloration	_____ Rosacea

What is your current skin care regimen? (Check all that apply)

_____ Cleanser	_____ Retin A	_____ Retinol	_____ Mask
_____ Toner	_____ Differin	_____ AHA	_____ Soap & Water Only
_____ Moisturizer	_____ Accutain	_____ Exfoliation	_____ Daily Sunblock

Do you currently use a mineral make-up? ____ Yes ____ No

If yes, what type? ____

Do you blush easily? ____ Yes ____ No

If yes, what are the contributing factors? (Ex: Emotions, Food, Temperature Change, etc) _________________

Please check all of which you have experienced? ____ Scars ____ Welts ____ Bumps ____ Hives ____ Other

Have you ever had eczema or psoriasis? ____ Yes ____ No

SUN HISTORY

Do you sunbathe or use a tanning bed? ____ Yes ____ No

If yes, how often? ____

Do you burn easily? ____ Yes ____ No

What effect does sun have on your skin? ____ Burn ____ Breakout ____ Tan ____ Peel ____ Rash ____ Other

Do you have a personal or family history of skin cancer? ____ Yes ____ No

If yes, relationship to you? ____

When was your last sun checkup? ____

FEMALE CLIENTS ONLY

Are you pregnant? ___ Yes ___ No

Are you trying to get pregnant? ___ Yes ___ No

Are you menopausal? ___ Yes ___ No

Do you take oral contraceptives? ___ Yes ___ No

MALE CLIENTS ONLY

Have you experienced shaving irritation? ___ Yes ___ No

Do you have ingrown hair? ___ Yes ___ No

Current shaving system? ___ Wet ___ Electric

HEALTH HISTORY

Are you presently under the care of a dermatologist? ____ Yes ____ No

Have you undergone surgery in the past 9 months? ____ Yes ____ No

Have you undergone radiotherapy or chemotherapy for any type of cancer? ____ Yes ____ No

If yes, please specify type of cancer: ____

Do you exercise or play any sports? ____ Yes ____ No

Do you heal quickly? ____ Yes ____ No

Do you wear contact lenses? ____ Yes ____ No

Do you smoke? ____ Yes ____ No

If yes, stop smoking.

How many glasses of water do you drink a day? _________

Please check all that apply:

_____ Thyroid: Hyper	_____ Vertigo	_____ HIV	_____ Hormonal Imbalance
_____ Thyroid: Hypo	_____ Herpes	_____ Claustrophobia	
_____ High Blood Pressure	_____ Hepatitis B	_____ Mononucleosis	
_____ Low Blood Pressure	_____ Hepatitis C	_____ Tuberculosis	

Inner Beauty
SKIN CARE
122 N. 4th Street - Suite 2010
Lake Mary, FL 32746
www.innerbeautysc.com

CONSENT FOR FACIAL TREATMENT

I understand all questions asked on these forms, and I have answered truthfully and honestly to the best of my knowledge. I fully understand that the services offered are not a substitute for medical care and treatment. I am aware that individual results are dependent upon my age, skin conditions, and lifestyle. I agree to actively participate in following all appointment schedules and home care procedures to the best of my ability, so that I may obtain maximum results. In the event that I may have additional questions or concerns regarding my treatments or suggested home care routine, I will consult with my facial specialist immediately.

I release and hold harmless the skin care specialist, Mindy Black, and Inner Beauty SkinCare, Inc. from any liability for any and all adverse reactions, which may result from these treatments.

I have read and fully understand this policy.

Date: ____/____/____

Signature: ________________________

Print Name: ________________________

CANCELLATION POLICY

We require 24 hours notice if a client cannot keep the scheduled office appointment. This allows us to accommodate other clients. All clients who cancel appointments within fewer than 24 hours notice will be subject to a $25 cancellation fee. We realize that occasionally 24 hours notice is not possible, so we will consider a one-time cancellation with no fee incurred.

Client initials ______