

# *Radiant Reflections Client History*

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

What is the most convenient day of the week for your appointments? \_\_\_\_\_.

What is the most convenient time of day for your appointments? \_\_\_\_\_.

How did you hear about Radiant Reflections? \_\_\_\_\_.

Would you like to be emailed notification of special offers, discounts or incentives? \_\_\_\_\_.

Email Address: \_\_\_\_\_

## *Your Health*

Within the last year have you been under the care of a dermatologist or other physician? \_\_\_\_\_ If so...list conditions that have been treated. \_\_\_\_\_.

List prescription medications, supplements, vitamins, diuretics, herbs and over the counter medications that you take regularly. \_\_\_\_\_

Have you had any health problems recently that have not been treated by a physician? \_\_\_\_\_ If so...please describe. \_\_\_\_\_

Do you smoke \_\_\_\_\_, exercise regularly \_\_\_\_\_, follow a restricted diet \_\_\_\_\_, wear contact lens \_\_\_\_\_

Do you have body piercing \_\_\_\_\_, metal implants \_\_\_\_\_, Where \_\_\_\_\_? Pacemaker yes or no?

Rate your level of stress on a scale of 1-4 (1=low, 4=high) \_\_\_\_\_.

## *Your Skin*

Do you have any special concerns pertaining to your face or body? If yes, please specify. \_\_\_\_\_

What skin care products do you currently use?

Face: soap\_\_\_\_, cleanser\_\_\_\_, toner\_\_\_\_, moisturizer\_\_\_\_, masque\_\_\_\_, exfoliator\_\_\_\_, eye products\_\_\_\_. Do you use a particular brand of skin care products? \_\_\_\_\_ If so please specify: \_\_\_\_\_.

Body: soap\_\_\_\_, shower gel\_\_\_\_, scrubs\_\_\_\_, oil\_\_\_\_, body moisturizer\_\_\_\_, depilatory products\_\_\_\_, self tanners\_\_\_\_.

Have you ever had chemical peels\_\_\_\_, microdermabrasion\_\_\_\_, or any other resurfacing treatments\_\_\_\_? If so, how long since your last treatment? \_\_\_\_\_.

Do you use any prescription skin care products, such as Accutane, Retin A, Renova, Adapalene? \_\_\_\_\_?

Are you currently using any of the following products? Glycolic acid\_\_\_\_, lactic acid\_\_\_\_, any exfoliating products\_\_\_\_,

Vitamin A derivatives (ie: retinol)\_\_\_\_\_?

**(Turn over for further questions)**

### *Moisture/Hydration*

How much plain water do you consume daily? \_\_\_\_\_

How many alcoholic beverages do you consume weekly? \_\_\_\_\_

Do you ever experience these conditions on your skin? Flakiness \_\_\_\_\_, tightness \_\_\_\_\_, obvious dryness \_\_\_\_\_

Do you use sunscreen daily on your face? \_\_\_\_\_, What SPF? \_\_\_\_\_ On your body? \_\_\_\_\_ What SPF? \_\_\_\_\_

Do you sunbathe or use tanning beds? \_\_\_\_\_ How often? \_\_\_\_\_

### *Capillary Activity*

Do you burn easily in moderate sunlight? \_\_\_\_\_

Do you blush easily when nervous? \_\_\_\_\_

Do you have a tendency to redness? \_\_\_\_\_

Do you suffer from sinus problems? \_\_\_\_\_

Have you even been diagnosed with Rosacea? \_\_\_\_\_

### *Nerve Activity*

Do you drink more than 4 caffeinated beverages daily? (Coffee, tea, soft drinks) \_\_\_\_\_

Do you ever experience a burning or itching sensation on your skin? \_\_\_\_\_ If so where? \_\_\_\_\_

Have you ever been diagnosed with psoriasis or eczema? \_\_\_\_\_

Have you ever had an allergic reaction or any type of reaction to any of the following? (Circle) Cosmetics, medicine, iodine, pollen, food, hydroxy acids, animals, fragrance, sunscreens, other? Please list \_\_\_\_\_

### *Female Clients*

Are you taking oral contraception? \_\_\_\_\_ If so list medication (If not listed on previous page) \_\_\_\_\_

Are you pregnant or trying to become pregnant? \_\_\_\_\_ Are you lactating? \_\_\_\_\_

Are you peri-menopausal ? \_\_\_\_\_ or have your reached menopause? \_\_\_\_\_

Are you taking hormone replacement therapy? \_\_\_\_\_ If so, list medication if not listed on previous page \_\_\_\_\_.

Do you notice any excessive hair growth on your face (lip, chin)? \_\_\_\_\_

### *Male Clients*

What is your current shaving system? \_\_\_\_\_

Do you experience irritation from shaving? \_\_\_\_\_

Do you experience ingrown hairs? \_\_\_\_\_

*The information given above is for your protection and safety. It is of utmost importance to give current health information. Your information will be held in strict confidence.*

I verify that the information given above is true and that if there are any changes I will notify my skin care therapist prior to treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_