Montebello Skin Care Studio

MDSKINCARE
REJUVENATING SOLUTIONS

131 Lafayette Ave 1st floor Suffern NY 10901

845-368-4420

Consultation Intake form

Client name_____

Client address_____

City_____

E-mail_____

Cell #_____

Home #_____

Work #_____

Age: ____under 21 ___21-30 ___31-40 ___41-50 ____51-60 ___60+

How did you hear about us? _____

Your Health

Questions to discuss every visit

*** **Have you started any new medication since your last visit?**

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1. Within the last year, have you been under a dermatologist's or other physician's care? ___yes ____No .

1A. Have you had any skin cancer? _____

***Are you receiving chemotherapy, or radiation? ____yes ___no

1B. Are you pregnant or trying to become pregnant? ___yes ___no

2. Allergies: Have you ever had a reaction to any of the following? _____cosmetic _____ Medicine ____iodine ____Pollen ____food_____Hydroxy acids _____animals ____fragrance ___sunscreens

3. Do you have metal implants, pacemaker, or body piercings? ____yes

___no

4. Within the last nine months, have you undergone surgery? ___yes ___no

5. Have you had any health problems in the past or present? ____yes ___no

If yes, please specify_____

6. List any medications, supplements, vitamins, diuretics, slimming tablets, etc. that your regularly take._____

7. Do you smoke? ____yes _____no

8. Do you exercise regularly? _____yes _____no

9. Do you wear contact lenses? ____yes _____no

10. Rate you stress level on a scale of 1 to 10 (1 = low stress, 10 =high stress

_____

Your Skin

11 Do you have any special skin problems pertaining to your body or face ___yes ____no

If yes, please specify_____

12. What skin care products (Brand) are you currently using?

_____

FACE: ___soap ___Cleanser ____Toner ____moisturizer _____masque ____Exfoliators

____Eye products

Body: ___Soap ____shower gel ___Scrubs ___Oil ___body moisturizer

_____ Self-tanners

13. Are you currently getting treated for Laser hair removal? ____yes ____no. If yes what part of the body? _____

Exfoliation History

14. Have you ever had a chemical peel, Microdermabrasion, or any resurfacing treatments? ____yes ____no _____in the last month? ___yes ____No

15. Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? ____yes ___no in the last 48 hours

____yes ____ no in the last 3 months? ____yes ___no

16. Are you currently using any products that contain of the following ingredients? ____Glycolic acid ____lactic acid ____any exfoliating scrubs _____any hydroxyl acid products _____ vitamin A derivatives (i.e., retinol)

Moisture Hydration

17. How much water do you consume daily? _____

18. How many alcoholic beverages do you consume weekly? _____

19. Do you ever experience the conditions? _____flakiness _____tightness _____obvious dryness, ___oily ____redness _____sensitive ____ Itchy ____Rosacea ____Acne ____breakouts

___congestion ____ black heads

20. Do you wear sunscreen on your face? ____Yes ___no

Body? ___yes ___no

21. Do you sunbathe or use tanning beds? ____yes _____no

Capillary activity

22. Do you burn easily in moderate sunlight? ____yes ___no

23. Do you blush easily when nervous? ____yes ____no

24. Do you have tendency to redness? _____yes ____no

25. Do you suffer from sinus problems? ____yes ____no

Oil Secretion

26. Do you ever experience oily shine during the day? ___yes ____no

27. Do you ever experience breakouts? ____yes ____no

Nerve activity

28. Do you drink more than 4 caffeinated beverages daily? (Coffee, tea, soft drinks) ___yes ___no

29. Do you ever experience a burning, itching sensation on your skin?

___yes ____no

30. What is your pain threshold? ____low ____medium ___high

31 Do you experience claustrophobia? ___yes ____no

32. What type of massage pressure do you prefer? ____light ____medium ___firm

Female Clients

33. Are you taking oral contraception? ____yes ___no / or have in the past? ____yes ___no

34. Are you lactating? ____YES ____NO.

35. Are you currently having or due for menstrual period? _____Yes

___no

36. What are your skin care goals and concerns?

_____

Male Clients

37. Do you have any shaving challenges? ___yes ___ no.

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client signature_____