



client profile

contact information

DATE

Name _____ Occupation _____

Address _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

May we leave a message? _____ Marital Status (circle one) Single Married Other Children? _____

Email Address _____ Date of Birth _____ Age _____

How did you hear about SKIN Medical Spa? _____

skin care concerns

These are areas of concern for me: (check all that apply)

- Fine lines & wrinkles
- Excess Underarm Sweating
- Rosacea/facial redness
- Sagging Skin
- Crows Feet
- Skincare
- Leg Veins
- Large Pores
- Laugh lines/folds around mouth
- Age spots/Freckles
- Spider Veins
- Other _____
- Excess Hair
- Acne
- Broken Capillaries on face or body

Please prioritize your top 5 concerns:

(1) _____ (2) _____ (3) _____ (4) _____ (5) _____

If you could change one thing about your skin, what would it be? _____

Have you ever been to a dermatologist? Y / N When and for what purpose? _____

Have you ever been on Accutane? Y / N If yes, when were you on it? _____

Have you used ANY of the following topical medications in the past 7 days? (please circle)

Retin-A Glycolic Acid Lactic Acid TriLuma Hydroquinone Other _____

What medications are you currently taking? _____

Have you taken any other medications in the last 7 days? _____

Do you take Herbs? Y / N If Yes, please list: _____

Past medical history - please list (i.e. hypertension, diabetes, other) _____

Do you have any allergies? Do you have any skin allergies? Have you ever had an allergic reaction to a skin product? Explain:

Please identify the names of the products you currently use:

Cleanser _____ Toner _____ Moisturizer _____ Eye cream _____

Exfoliant _____ Night cream _____ Sunscreen _____ Glycolic Products _____

Have you ever had an acid peel? Y / N If yes, when was your last one? _____

Have you ever had laser surgery? Y / N If yes, when was your last one? _____

Have you had a Microdermabrasion? Y / N If yes, when was your last one? _____

Have you had collagen or other fillers? Y / N If yes, when was your last one? _____

How often do you get collagen, Restylane or Juvederm? _____



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Do you get cold sores, fever blisters or herpes outbreak? Y / N If yes, how many per year? _____

Do you go to a tanning salon? Y / N Do you use self-tanning products? Y / N

Do you use sunscreen regularly? Y / N What SPF? (please circle one) 8 15 30 45

Do you have any Autoimmune or neurological disorders (multiple sclerosis, guillain-barre disease)? Y / N

If yes, please explain: _____

Have you had any other cosmetic surgeries or procedures? Y / N If yes, please explain: _____

Have you or any member of your family had skin cancer? Y / N If yes, who? _____

How often does your skin feel tight?	Frequently	Occasionally	Rarely
How often does your skin feel or look shiny?	Frequently	Occasionally	Rarely
How often does you experience acne breakouts?	Frequently	Occasionally	Rarely
How noticeable are your pores?	Very	A little	Not

fitzpatrick classification system

please select the skin type that seems to describe your skin the best:

SKIN TYPE	SKIN COLOR	CHARACTERISTICS
<input type="radio"/> I	White	Always burns, never tans
<input type="radio"/> II	White	Usually burns, tans less than average
<input type="radio"/> III	White	Sometimes mild burn, tans about average
<input type="radio"/> IV	Brown	Rarely burns, tans more than average
<input type="radio"/> V	Brown	Rarely burns, tans profusely
<input type="radio"/> VI	Black	Never burns, deeply pigmented

What is your ethnicity? (i.e. Irish, Native American) _____

women only

Are you pregnant or lactating? Y / N

Are you trying to become pregnant? Y / N

Did you get hyperpigmentation or masking during pregnancy? Y / N or N/A

Are you menopausal? Y / N

When was the date of your last menstrual period? _____

acknowledgement & treatment consent

I acknowledge that SKIN Medical Spa and ReGenesis MSO Inc.'s scope of medical treatment is limited to minor skin concerns and aesthetically oriented services. It is in no way a substitute or replacement for care by a dermatologist for healthcare concerns outside the scope defined above. I remain responsible for my own dermatologic medical care including but not limited to conditions such as skin cancer, melanoma, psoriasis, eczema, among others. I therefore hereby release SKIN Medical Spa and Dr. Robert Colvin and all of its employees or affiliates from all responsibility in connection with the diagnosis and treatment of such skin conditions.

I authorize SKIN Medical Spa for treatment of cosmetic and minor skin care. I understand that I am financially responsible for services. I understand that SKIN Medical Spa has a 24-hour cancellation policy. I also understand that if I fail to cancel or change my appointment, a charge will be applied.

Client Signature _____ Date _____

Reviewed by _____ Date _____