

# SKIN THERAPY CONSULTATION FORM

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please select the treatments you are interested in:

- |                                                                        |                                                    |
|------------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Medical skin Therapy (Clinical Facials/Peels) | <input type="checkbox"/> Laser Vein Therapy        |
| <input type="checkbox"/> Photorejuvenation/Laser Facial                | <input type="checkbox"/> Laser Skin Rejuvenation   |
| <input type="checkbox"/> Laser Hair Removal                            | <input type="checkbox"/> Acne Management Therapy   |
|                                                                        | <input type="checkbox"/> Medical Wrinkle Reduction |

Have you received any of the above treatments in the past?      Yes      No  
If yes, please indicate: \_\_\_\_\_

Please check the concerns that you are experiencing:

- |                                              |                                            |
|----------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Wrinkles/Anti-Aging | <input type="checkbox"/> Scarring          |
| <input type="checkbox"/> Excess Hair         | <input type="checkbox"/> Hyperpigmentation |
| <input type="checkbox"/> Rosacea/Redness     | <input type="checkbox"/> Hypopigmentation  |
| <input type="checkbox"/> Spider Veins        | <input type="checkbox"/> Sun Damage        |
| <input type="checkbox"/> Broken Capillaries  | <input type="checkbox"/> Excess Sweating   |
| <input type="checkbox"/> Acne                | <input type="checkbox"/> Other: _____      |

When did your concern start?  
\_\_\_\_\_

Where are on your body are you experiencing this concern?  
\_\_\_\_\_

What are your symptoms?  
\_\_\_\_\_

Does anything aggravate the concern?  
\_\_\_\_\_

Does anything relieve the concern?  
\_\_\_\_\_

In general, how do you feel about your skin?  
\_\_\_\_\_

I certify that all of the above information is accurate and correct:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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

- Normal
- Dry
- Oily
- Combination
- Acne prone
- Sensitive dry
- Sensitive oily
- Reactive
- Rosacea prone
- Always burns (I)
- Usually burns
- Sometimes burns
- Rarely burns
- Never burns

**Current Skin Care Regime**

Cleanser: \_\_\_\_\_  
 Toner: \_\_\_\_\_  
 Moisturizer: \_\_\_\_\_  
 Night Creams: \_\_\_\_\_  
 Eye Creams: \_\_\_\_\_  
 Exfoliants: \_\_\_\_\_  
 Masks: \_\_\_\_\_  
 Treatment Serums: \_\_\_\_\_  
 Sunscreen: \_\_\_\_\_  
 Other products: \_\_\_\_\_

**General Questions:**

Do you use tanning salon services?      Yes      No

If yes, how often?

Have you ever used Accutane?      Yes      No

If yes, how long ago?

Are you currently using any photosensitive medications?      Yes      No

Have you ever received Gold Therapy?      Yes      No

In general, what are you expectations for treatment?

I certify that all of the above information is accurate and correct:

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_