Kari Lynn & COMPANY

SKINCARE SPECIALISTS

Intense Pulsed Light (IPL) & Clinical Skin Treatment Questionnaire

Please answer the following questions so that we may have a better understanding of your general health and lifestyle, thereby enabling us to accurately analyze and assess your skincare needs.

Date ____/____/____

Name (please print clearly)			Date of Birth
			/ /
Street Address	**City**	**State**	**Zip Code**
Email Address	**Home Phone**		
Work Phone	**Cell Phone**		
Who may we thank for referring you?			

Which of the following have you had in the past or do you currently have? (Please check all that apply.)

❑Diabetes	❑ Gold Therapy	❑ Seizure Disorder (Epilepsy)	❑ Skin Cancer	❑ Chemotherapy
❑Asthma	❑ Thyroid Disorder	❑ Polycystic Ovarian Syndrome	❑ Irregular Menses	❑ Fainting Spells
❑Keloid	❑ Dermatitis	❑ High Blood Pressure	❑ Heart Disease	❑ Irregular Pulse
❑Lupus	❑ Hepatitis	❑ Herpes Simplex Infections/Fever Blisters		

Are you presently under a physician's care for any reason? ❑ Yes ❑ No

If yes, please explain: _____

Are you presently on any mood altering or antidepression medication? ❑ Yes ❑ No

Please list any medications you are currently taking including herbal supplements and vitamins:

_____

Are you allergic to aspirin? ❑ Yes ❑ No
Do you have any other allergies? ❑ Yes ❑ No
If yes, please list:

Do you smoke? ❑ Yes ❑ No
Are you on a diet? ❑ Yes ❑ No
Do you exercise? ❑ Yes ❑ No
Do you wear contact lenses? ❑ Yes ❑ No
Have you had skin treatments (facials) before? ❑ Yes ❑ No
Have you had any form of hair removal besides shaving (e.g. waxing, IPL)? ❑ Yes ❑ No
Have you had permanent cosmetics? ❑ Yes ❑ No

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Female Clients

Are you on hormone replacement therapy? ❑ Yes ❑ No
Are you presently on some form of birth control? ❑ Yes ❑ No
Are you pregnant or planning to be? ❑ Yes ❑ No

Intense Pulsed Light (IPL) Clients

Which areas do you wish to have treated? (Please check all that apply.)
❑ Face ❑ Neck ❑ Underarm ❑ Legs ❑ Back ❑ Chest ❑ Bikini Line

Other: _____

All Clients

Are you presently using any of the following? (Please check all that apply.)
❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Topical Vitamin C
❑ Hydroquinone ❑ Retinoid (Vitamin A derivatives e.g. Retin A, Renova, Differin)

How would you describe your skin? (Please check all that apply.)
❑ Oily ❑ Dry ❑ Combination ❑ Normal ❑ Sensitive

Have you had any of the following? (Please check all that apply.)
❑ Cosmetic Surgery ❑ Botox Injections ❑ Laser Resurfacing ❑ Chemical Peels ❑ Other: _____

Which conditions do you wish to improve? (Please check all that apply.)
❑ Hyperpigmentation (brown spots) ❑ Acne ❑ Sun Damage ❑ Large Pores ❑ Small Pores
❑ Scarring ❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Psoriasis ❑ Melasma ❑ Rosacea
❑ Eczema ❑ Broken Surface Capillaries

Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No
Do you use sunscreen/sunblock? ❑ Yes ❑ No
Do you currently have a tan? ❑ Yes ❑ No
Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No

Do you scar easily? ❑ Yes ❑ No
Do you heal quickly? ❑ Yes ❑ No

Do you have or have you ever had acne? ❑ Yes ❑ No
Are you using or have you ever used medications for acne? ❑ Yes ❑ No
Acne Medication(s):

Have you seen a dermatologist in the past year? ❑ Yes ❑ No
Dermatologist's Name and Reason for Visit:

What skincare products are you currently using?

What is it about your skin that you would like to change?

Is there any other information I should know before beginning your treatment?

To the best of my knowledge, the information I've provided here is true. I understand that this is confidential and will not be disclosed without my written consent.

Client or Legal Guardian Signature

Kari Lynn & COMPANY

SKINCARE SPECIALISTS

Skin Peel, Microdermabrasion, Intense Pulsed Light & GentleWave Treatments

Client Name _____ **Date of Birth** ___/___/___

I certify that no changes have occurred in my health history that would preclude me from being treated today. I further acknowledge that I have been given verbal, as well as written instructions, pertaining to my skin treatment, post care recommendations, and daily skincare regimen. I know if I experience any complications or an allergic reaction, I am to contact my clinical aesthetician immediately.

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___

Signature _____ **Date** ___/___/___