L. Zen Skin Care and Health Studio, LLC
New Client Skin Consult Intake Form

(Circle One) Miss. Ms. Mrs. Mr. Dr. Date:_____

First Name:_____ _____ Last Name:_____

Address:_____

City:_____ State: _____ Zip:_____

Mobile Phone: _____ Home Phone:_____

Work Phone:_____ Occupation:_____

Email Address: _____

Date of Birth:_____ Age:_____

How would you describe your skin? ☐ Oily ☐ Sensitive ☐ Dry ☐ Normal ☐ Combination

What is your hereditary background? _____

Have you ever received the following procedures?

Procedure	Frequency	Date of last Treatment
Facials		
Chemical Peels		
Dermaplanning		
Microdermabrasion		
Laser Hair Removal		
Esthetic Laser Treatment (IPL, Fraxel, etc)		
Radio Frequency (RF) Treatments		
Microneedling		
PRP		
Facial Ultrasound		
LED Treatment		
Facial Waxing		
Eyelash/Brow Tinting		

Other:_____

IF yes, please explain:_____

What skin care products do you use on daily basis?

SkinCare Products	Brand	Frequency
Cleanser		
Toner		
AM Moisturizer		
PM Moisturizer		
Sunscreen		
Corrective Serum		
Corrective Serum		
Facial Scrub		
Mask		
Mask		
Eye Cream		
Other -		
Other -		

Have you used any of the following topical/oral dermatological medications?

Medication	Number of Years	Date Last Used
Accutane		
Retin-A		
Hydroquinone		
Differin		
Tazarac		
Topical Antibiotics		
Renova		
Trentinoin		
Avage		
EpiDuo		
Ziana		
Alpha Hydroxy Acids (glycolic, lactic, malic)		
Beta Hydroxy Acid (salicylic)		
Benzoyl Peroxide		

Other:_____

If yes, please explain:_____

Are you currently taking birth control pills or have an IUD? (circle) Yes No

Are you currently pregnant or breastfeeding? (circle) Yes No

Are you currently undergoing any hormone therapies or taking any infertility drugs? (circle) Yes No

If yes, please explain:_____

Current Medications (include over the counter)

1. _____

2. _____

Current Herbal Supplements and Vitamins

1. _____

2. _____

Current Medications (continued)

3. _____

4. _____

5. _____

Current Herbal Supplements and Vitamins (Cont.)

3. _____

4. _____

5. _____

Please List Allergies

Foods	Medications/Latex	Product Ingredients	Environmental

Please List Daily Habits

Habits	Never	Daily Intake	# of Years	Date Last Used
Alcohol				
Caffeine				
Tobacco				
Drugs				
Water				
Sugar				
Carbs/Yeast				

Are you having at least one bowel movement per day? (circle) Yes No

Do you wear contact lenses or eyeglasses? (circle) Yes No

Have you had excessive sun exposure in the last few days? (circle) Yes No

Will you be having excessive sun exposure on a vacation or in the near future? (circle) Yes No

Are you in the habit of using tanning booths? (circle) Yes No

Medical History

Have you ever had any of the following conditions?

Condition	Yes	No	Currently	Date of Last Diagnosis
Acne				
Rosacea				
Cold Sores/ Fever Blisters				
Skin Disorder (i.e. Dermatitis)				
Hypertrophic Scarring (i.e. Keloids)				
Fibroids				
Polycystic Ovarian Syndrome (PCOS)				
Constipation				
Diabetes				
Cancer				
HIV/AIDS				
Lupus				
Heart Conditions				
Pacemaker/Metal Implants				
Arthritis				
Seizures				
Severe Headaches/Migraines				
Hepatitis				
Bleeding Disorder (i.e. Anemia)				
Thyroid Disease				

Do you have any other medical concerns that have not been covered in this form? (circle) Yes No

If yes, please explain: _____

What are your current top 3 concerns with your skin and what improvements would you like to see?

1. _____

2. _____

3. _____

I understand, have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____

Parent/Guardian Signature (If under age 18) _____ Date: _____

Esthetician/Practitioner Signature: _____ Date: _____