(Facial Intake Form)

Dermalogica Face Mapping Consultation Card

Client Name: ________________________ Therapist: ___________________
Client Address: __________________________________ Apt/unit: _______
City: ___________________ Province: _______ Postal Code: ____________
E-mail address: ________________________ @________________________
Telephone: home (___) ______________ work (___) ____________
Birthday: Month__________ Day_______
Under 21___ 21-30___ 31-40___ 41-50___ 51-60___ 60+___
How did you hear about us? ____

Your Health

Within the last year have you been under a dermatologist or others physician's care?
Yes___ No___

Within the last nine months, have you undergone any surgery? Yes___ No___
If yes please specify ___________________________________

Have you had any health problems in the past or present? Yes___ No___
If yes please specify ___________________________________

List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly ____

Do you smoke? Yes___ No___
Do you exercise regularly? Yes___ No___
Do you follow a restricted diet? Yes___ No___
Do you wear contact lenses? Yes___ No___
Do you have metal implants, a pacemaker or body piercings? Yes___ No___
Rate your level of stress on a scale of 1-4 (1=low stress 4=high stress) ____

Your Skin

Do you have any special skin problems pertaining to your face or body? Yes___ No___
If yes please specify? ____

What skin care products do you currently use?
Face: soap ___ cleanser ___ toner___ moisturizer ___ masque ___ exfoliator ___ eye products ___
Body: soap ___ shower gel ___ scrubs ___ oil ___ body moisturizer ___ depilatory products ___
self tanners ___

Exfoliation History

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?
Yes ___ No___ In the last month? Yes ___ No___

Do you use Acutane, Retin A, Renova, Adapalene or any other prescription skin products?
Yes ___ No___ In the last three months? Yes ___ No ___

Are you currently using any products that contain the following ingredients?
glycolic acid ___ lactic acid ___ any exfoliating scrubs ___ any hydroxy acid product ___
vitamin A derivatives (i.e. retinol) ___

Moisture Hydration

How much plain water do you consume daily? ____________
How many alcoholic beverages do you consume weekly? _____________
Do you ever experience these conditions on your skin?
Flakiness ___ Tightness ___ Obvious Dryness ___
What SPF sunscreen do you use on your face? ________ Body? _________
Do you sunbathe or use tanning beds? Yes ___ No ___

Capillary Activity

Do you burn easily in moderate sunlight? Yes ___ No ___
Do you blush easily when nervous? Yes ___ No ___
Do you have a tendency to redness? Yes ___ No ___
Do you suffer from sinus problems? Yes ___ No ___

Oil Secretion

Do you ever experience oily shine during the day? Yes ___ No ___ Occasionally ___
Do you ever experience skin breakouts? Yes ___ No ___ Occasionally ___

Nerve Activity

Do you drink more than 4 caffeinated beverages daily? Yes ___ No ___
Do you ever experience a burning, itching sensation on your skin? Yes ___ No ___
What is your pain threshold? Low ___ Medium ___ High ___
Have you ever experienced claustrophobia? Yes ___ No ___
What type of massage pressure do you prefer? Light ___ Medium ___ Firm ___
Have you ever had a reaction to any of the following?
Cosmetics ___ Medicine ___ Iodine ___ Pollen ___ Food ___ Hydroxy Acids ___ Animals ___
Fragrance ___ Sunscreens ___ Other ___________________________________

Female Clients Only

Are you taking oral contraception? Yes ___ No___
Are you pregnant or trying to become pregnant? Yes ___ No ___
Are you lactating? Yes ___ No ___

Male Clients Only

What is your current shaving system? Electric ___ Wet Shave ___
Do you experience irritation from shaving? Yes ___ No ___
Do you experience ingrown hairs? Yes ___ No ___

Questions To Discuss Every Visit

Are you currently having or due for your menstrual period? Yes ___ No ___
Have you started any new medication since your last visit? Yes ___ No ___
Have you had any recent dental x-rays? Yes ___ No ___
What are your skin care goals? ____

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: ____________________________ Date: ____________________________