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 client signature date

client signature date client signature date

client signature date client signature date

client signature date client signature date

client signature date client signature date

client signature date client signature date

This consultation card is used to evaluate your individual skin care needs. We will maintain the confidentiality of this information, and will disclose this information only: (i) to our staff members, (ii) to quality assurance and quality control personnel, (iii) to our product supplier and manufacturer. We will not provide this information to anyone else, except as required by law, and we will not sell this information to anyone. We may, however, contact you with product-related information.

treatment / product record

date	treatment/products used in treatment/contraindications/notes	samples given	skin therapist

date	treatment/products used in treatment/contraindications/notes	samples given	skin therapist

treatment / product record

client name **skin therapist**

last first

client address apt/unit

city state zip

email

phone home ( ) cell ( )

birthday ☐ under 21 ☐ 21-30 ☐ 31- 40 ☐ 41– 50 ☐ 51- 60 ☐ 60+

month day

how did you hear about us?

dermalogica® consultation card

dermalogica® face mapping®

dermalogica® body mapping™

your health

1 Within the last year, have you been under a dermatologist's or other physician's care? ☐ yes ☐ no

If yes, please specify _____

2 Have you had any health problems in the past or present? ☐ yes ☐ no

If yes, please specify _____

3 List any medications, supplements, vitamins, diuretics, slimming pills, Isotretinoin, etc. that you take regularly.

_____

4 Do you smoke? ☐ yes ☐ no

5 Do you exercise regularly? ☐ yes ☐ no

6 Do you follow a restricted diet? ☐ yes ☐ no

7 Do you wear contact lenses? ☐ yes ☐ no

8 Do you have metal implants, a pacemaker or body piercings? ☐ yes ☐ no

9 Rate your level of stress on a scale of 1 to 5 (1 = low stress, 5 = high stress) _____

10 Do you have any allergies? ☐ yes ☐ no

If yes, please specify _____

11 Do you sunbathe or use tanning beds? ☐ yes ☐ no

12 Do you drink more than 4 caffeinated beverages daily (coffee, tea, soft drinks)? ☐ yes ☐ no

13 Have you ever experienced claustrophobia? ☐ yes ☐ no

your skin

14 What are your specific concerns/challenges with your skin? _____

15 What skin care products are you currently using?

face: ☐ soap ☐ cleanser ☐ toner ☐ moisturizer ☐ masque ☐ exfoliator ☐ eye products

body: ☐ soap ☐ shower gel ☐ scrubs ☐ oil ☐ body moisturizer ☐ depilatory products ☐ self tanners

16 Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? ☐ yes ☐ no

In the last month? ☐ yes ☐ no

17 Do you use Retin-A, Renova, Adapalene or any other prescription skin products? ☐ yes ☐ no

In the last 3 months? ☐ yes ☐ no

18 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)

19 Do you ever experience these conditions on your skin? ☐ flakiness ☐ tightness ☐ obvious dryness

20 What SPF sunscreen do you use on your face? _____ Body? _____

21 Do you burn easily in moderate sunlight? ☐ yes ☐ no

22 Do you have a tendency to redness? ☐ yes ☐ no

23 Do you suffer from sinus problems? ☐ yes ☐ no

24 Do you ever experience burning, itching or stinging sensations on your skin? ☐ yes ☐ no

female clients only

25 Are you taking oral contraception? ☐ yes ☐ no

26 Are you pregnant or trying to become pregnant? ☐ yes ☐ no

27 Are you lactating? ☐ yes ☐ no

28 Are you currently having or due for your menstrual period? ☐ yes ☐ no

male clients only

29 Do you have any shaving challenges? ☐ yes ☐ no

If yes, please specify _____

questions to discuss every visit

30 Have you started any new medication since your last visit? ☐ yes ☐ no