CLIENT QUESTIONNAIRE

YOUR INFORMATION

Name _____ Age _____DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____Cell Phone _____ Email _____

Ethnicity _____

MEDICATIONS

Medication	When	How Long	Medication	When	How Long
Antibiotics			Androstendione		
Accutane			Testosterone		
Benzoyl Peroxide			Progesterone		
Retin A			Thyroid		
Cream or Gel?			Gonadotrophin		
Tazorac			Danzol		
Differin			Cyclosporin		
Azelex			Lithium		
Avita			Isoniazid		
Cleocin-T			Immuran		
E-mycin-T			Disulfuram		
Copaxone			Dilantin/Tegretol		
Corticosteroids			Steroids		
Quinine			Marijuana		
Other Meds			Cocaine/Speed		

MEDICAL HISTORY – please check all that apply

Herpes Simplex		HIV/AIDS		Hemophilia	
Eczema		Thyroid Problems		Lupus	
Psoriasis		Hormone Problems		Anemia	
Hepatitis		Hysterectomy		High Blood Pressure	
Cancer		Ovary(ies) Removed		Diabetes	
Staph Infection/MRSA		Pacemaker		Metal Pins in Body	

Your primary care physician:

Name: _____ Phone: _____

Are you under a dermatologist's or other skin physician's care ? Yes □ No □

If yes, doctor's name: _____

LIFESTYLE CONSIDERATIONS

1. Have you ever had any reaction to any products or anything you have put on your face? Yes □ No □
   If yes, what products? _____
2. Please check any of these you are allergic to: Sulfur □ Aspirin □ Latex □

   List any other allergies you know of: _____
3. Do you smoke? Yes □ No □
4. Do you use fabric softener or fabric softener sheets in the dryer? Yes □ No □
5. Do you swim in a chlorinated pool? Yes □ No □
6. Do you work around chemicals, tars, oils, grease or inks? Yes □ No □
7. Occupation: _____ Do you work nights? Yes □ No □
8. Are you currently under a lot of stress? Yes □ No □ (common stress = job loss, new job, wedding, romantic breakup, death in the family or close friend, graduation, difficult home life, long commute, heavily scheduled)
9. **Women:** Do you use birth control bills, shots or use an IUD? Yes □ No □

   If so, which do you use? _____ What brand of pill? _____ Are you pregnant or nursing? Yes □ No □
10. **Men:** Do you have shaving irritation? Yes □ No □
    What do you use for shaving? _____
11. Diet – do you consume the following?

Foods	✓	How often per week	Foods	✓	How often per week
Fast Food			Peanuts		
Processed Food			Sushi		
Salty Snacks			Kelp and Seaweed		
Milk/Yogurt			Miso Soup		
Cheese			Soy		
Whey or Soy Protein			Vitamins		
Peanut Butter			Seafood		

PRODUCTS CURRENTLY USING – Provide product names.

Cleanser	
Toner	
Serums	
Moisturizers	
Sunscreen	
Mask	
Foundation	
Blush	
Exfoliant (acids or scrubs)	
Acne Medications	

OTHER TREATMENTS: What else have you done for your skin in the last 90 days?

Glycolic/Lactic/Mandelic Peels	When?	Where?
Other Chemical Peels		
If so, what kind:		
Microdermabrasion		
Dermabrasion		
Laser Hair Removal		
Laser Rejuvenation/Resurfacing		
Skin Cancer Removal		
Facial Waxing		
Electrolysis		
Other:		

REZENERAT TREATMENT (please circle any contraindication you have or have had in the past and initial)

_____ I understand there are certain contraindications that would preclude me from receiving a Rezenerate treatment including: Keloid scars, active inflammation, history of actinic(solar) keratosis, history of herpes simplex infection, history of diabetes, raised moles, warts, skin tags, scleroderma, collagen vascular disease, blood clotting problem, active bacterial or fungal infection, immune suppression. Not recommended for women who are pregnant or nursing.

MICRODERMABRATION (please circle any contraindication you have or have had in the past and initial)

_____ I understand there are certain contraindications that would preclude me from receiving Microdermabrasion treatment including: Undiagnosed lesions, recent active weeping acne active rosacea, auto-immune system disorders* Epilepsy, recent waxing.

_____ I understand that the use of Botox®, Juvederm®, Restylane®, and any other injectable must be disclosed prior to treatment. It is recommended to wait a full two weeks after receiving injections before starting microdermabrasion.
Injectables received:_____ Date of injection:_____

MICROCURRENT TREATMENT (please circle any contraindication you have or have had in the past and initial)

This portion of this consent document informs you concerning Microcurrent Facial Rejuvenation treatments. It is important that you read this information carefully. Microcurrent is a non-invasive, low level of current that mirrors the body's own natural electrical impulses that stimulates ATP (Adenosine Triphosphate), the body's healing and rejuvenating properties.
_____ I understand there are certain contraindications that would preclude me from receiving microcurrent treatments, including embolism, epilepsy, cancer, pacemaker use, phlebitis, pregnancy and thrombosis.

_____ I understand that the use of Botox®, Juvederm®, Restylane®, and any other injectable must be disclosed prior to treatment. It is recommended to wait a full two weeks after receiving injections before starting microcurrent. Injectable received:_____ Date of injection:_____

_____ I understand that microcurrent treatments involve conducting mild electrical currents through the body.

_____ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

_____ I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or a metallic taste in the mouth during the procedure.

_____ I understand that while the goal of this treatment is to improve the vitality/tone/firmness of the skin, no specific guarantees of the result can be made. I further understand that my failure to follow post home care instructions may also lead to undesired results.

_____ I am disclosing all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products (you may write on the back side of this page if you need more room): Health history:_____

HIGH FREQUENCY TREATMENT/SKIN CLASSIC

(please circle any contraindication you have or have had in the past and initial)

_____ I understand there are certain contraindications that would preclude me from receiving a High Frequency treatment including: having a pacemaker, pregnancy, lupus, Accutane users, Melasma, Moles, any blood disorder.

_____ Several factors including skin color, age, hormonal activity, inherited conditions, and other influences may decrease effectiveness of treatments.

_____ I am disclosing all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products (you may write on the back side of this page if you need more room): Health history:_____

CLIENT CONSENT

The undersigned acknowledge that Topeka Acne Skin Care has explained the nature of all the above treatment/procedures including the risks and dangers inherent like: infection. hyper or hypo pigmentation, redness, edema, or bruising. As in any cosmetic procedure, the treatment goal is for esthetic improvement, not perfection. I understand that results will vary between individuals. I understand that the treatment I'm receiving is cosmetic and not a medical procedure.

I certify that I have read and fully understand the above paragraphs, that I have had enough opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above. I have read the guidelines that need to be followed after the treatment and will follow the steps as listed above.

I have disclosing all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products.

Print Name_____
Signature_____ Date_____

How did you hear about us? ____