Harrogate
Health & Beauty
Cosmetic Clinic

Client Questionnaire – Skin & Health

Please answer the following questions thoroughly and completely, as this provides a better understanding of your general health, lifestyle and skin care concerns; thereby enabling the use of the most effective clinic and home care recommendations for you.

Name	
Date of Birth	
Address	
Email	
Telephone	

Skin Care History

How do you find your skin at present?

Any further comments appreciated

What improvement would you like to see?

Any further comments appreciated

Please tick all that apply to your skin type:

[ ] Discoloration
[ ] Dry, flaky skin
[ ] Acne, breakouts
[ ] Enlarged pores
[ ] Dilated capillaries
[ ] Loss of facial contours
[ ] Redness
[ ] Fine lines & wrinkles
[ ] Oily skin
[ ] Acne scarring
[ ] Rosacea
[ ] Uneven texture
[ ] Dark under-eye circles

What skin care do you currently use?

Morning and evening products/regime

Please tick if you have any of these conditions:

[ ] Diabetes
[ ] Asthma
[ ] Thyroid condition
[ ] High blood pressure
[ ] Epilepsy
[ ] Heart condition
[ ] Have/had cancer

What type of skin do you think you have?

[ ] Dry
[ ] Normal
[ ] Oily
[ ] Combination

Do you have a history with acne?

Please outline details

Have you ever used any medications for acne?

Please outline details

Do you sunbathe or participate in outdoor activities?

Please outline details

Have you ever had a reaction to any skin care product?

Please outline details

Are you currently using or have used any of the following:

[ ] Retinol/Vitamin C
[ ] Salicylic Acid
[ ] Benzoyl Peroxide
[ ] Topical Antibiotics
[ ] Roaccutane
[ ] Glycolic Acid
[ ] Self Tan
[ ] Hydroquinone
[ ] Topical Steroids

Have you ever, or are you currently receiving skin treatments?

Please outline details

[ ] Chemical Peels
[ ] Facial Injections
[ ] Microdermabrasion
[ ] Radio frequency
[ ] Waxing
[ ] Laser Resurfacing
[ ] Permanent Cosmetics
[ ] Microneedling
[ ] Laser Hair Removal
[ ] Electrolysis

When was your last treatment?

Please outline details

Have you ever had any complications with a treatment?

Please outline details

General Health

Are you currently under the care of a physician?

Please outline details

Are you currently taking any medication?

Please outline details

Are you allergic to aspirin?

[ ] Yes [ ] No

Do you have an known allergies?

Please outline details

Female Clients

Are you on hormone replacement therapy?

[ ] Yes [ ] No

Are you currently taking birth control pills?

[ ] Yes [ ] No

Are you pregnant or breastfeeding?

[ ] Yes [ ] No

Please read and sign the following:

1. Tingling. You may feel some discomfort when treatment occurs. If the treatment is too uncomfortable, please indicate this to your therapist, who will remove the product from the your skin. You may also experience “hot spots” and/or crusting due to deeper penetration in specific areas.
2. Headaches. You may experience headache, nausea or dizziness during the treatment – although recorded cases are rare.
3. Hyperpigmentation. May occur in some cases. We absolutely insist that sunscreen is used straight after the peels and during the treatment period to ensure that this does not happen.

Please confirm that you have none of the following, before agreeing to go ahead with the peel.

Pregnancy	Use of Roaccutane
Cold sores	Herpes outbreak
Allergy to Aspirin	Use of Retin A/Retinova/Retinol Products
Known allergy to AHA’s	Plastic surgery in the last 6 months

Further considerations for consent

1. I acknowledge that no guarantee has been given to me as the condition of the complexion, skin pore size, wrinkle reduction, or the amount of percentage of improvement expected following the treatment.
2. I acknowledge that for many conditions, more than one peel may be required in certain areas to achieve the desired result. In fact, a course of a minimum of 6 is recommended for best results.
3. I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure that I herein request and authorise.
4. If I know or suspect that I may be pregnant, I will inform the operator prior to treatment.

Consent

By signing below, I acknowledge that I have read the foregoing informed consent regarding the peel(s) and I feel I have been adequately informed regarding the associated risks. I hereby give consent to a peel procedure to be performed by a qualified person.

Signature

Please sign and date here

	Date	Reference	Notes	Practitioners & patient's signature
1				
2				
3				
4				