

Skincare History



Name _____ Date _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____
 Date Of Birth _____ Email _____
 Referred By _____ Occupation _____

How did you hear about Tigerlilly Day Spa and Salon? _____

Do you have a particular reason for leaving your last spa/salon? _____

Medical History

Are you currently under a doctor's care? Yes _____ No _____

Have you had surgery in the past year? Yes _____ No _____

Do you have any of the following? If so, please circle all that apply.

- | | | |
|----------------|----------------|-------------------|
| Diabetes | Claustrophobia | Varicose Veins |
| Cancer | Epilepsy | Thyroid |
| Heart Problems | Hysterectomy | Hormone Imbalance |

Please list any medications taken regularly _____

Do you...

Smoke? Yes _____ No _____

Use Retin A? Yes _____ No _____

Ever used the acne drug Accutane? Yes _____ No _____

Follow a restricted diet? Yes _____ No _____

Exercise regularly? Yes _____ No _____

Have regular sleep patterns? Yes _____ No _____

Have your hair frosted, highlighted or chemically lightened? Yes _____ No _____

Wear contact lenses? Yes _____ No _____

Have metal implants or a pacemaker? Yes _____ No _____

What is the temperature of water with which you cleanse? Cool _____ Warm _____ Hot _____

Do you have any concerns about your skin? _____

What type of skin products are you currently using?

Soap _____ Toner _____ Mask _____ Cleanser _____ Moisturizer _____ Scrub/Exfoliant _____

Do you experience breakthrough oily shine during the day? Yes _____ No _____

Do you experience skin breakouts? Yes _____ No _____ Occasionally _____

How much plain water do you consume daily? _____ glasses

How many alcoholic beverages do you consume weekly? 1-3 _____ 4+ _____

Do you ever experience these conditions on your skin? Flakiness _____ Tightness _____ Dryness _____

If you sunbathe, do you use sunscreen/sunblock on your skin? Yes _____ No _____

Do you burn easily in moderate sunlight? Yes _____ No _____

Do you blush when nervous? Yes _____ No _____

Do you have a tendency to redness? Yes _____ No _____

Are you currently experiencing sinus problems? Yes _____ No _____

Do you drink caffinated beverages (coffee, tea, soda)? Yes _____ No _____
 If yes, how many daily? _____

At what level do you consider your pain threshold to be? Low _____ Medium _____ High _____

What type of massage pressure do you prefer? Light _____ Firm _____

Have you had any recent dental x-rays? Yes _____ No _____

Have you ever had a reaction to the following? (please circle those applicable)

Cosmetics	Pollen	Animals	Medicine	Food
Fragrance	Iodine	AHA's	Sunscreens	Shellfish
Seaweed	Other _____			

Female Clients Only

Are you taking oral contraceptives? Yes _____ No _____

Are you pregnant or trying to become pregnant? Yes _____ No _____

Are you currently having/due for your menstrual period? Yes _____ No _____

Male Clients Only

What is your current shaving system? Wet _____ Electric _____

Do you ever experience irritation from shaving? Yes _____ No _____

I confirm that to the best of my knowledge the answers I have given are correct and I have not withheld any information that may be relevant to my treatment.

Signature _____ Date _____

Treatment Notes: