

CLIENT INFO

Name

Date

Address

Phone

Email

PERSONAL INFORMATION

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Do you have any health problems or concerns that we need to be aware of before we begin this treatment? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 2. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Any recent surgery on your face, neck and shoulders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you taken Accutane® within the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you used Retin-A®/Renova®, or any powerful alpha hydroxy acids within the past 3 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a medical peel within the past 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have a pacemaker or any pins in bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you currently wear contact lenses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are you currently under a physician's care for any skin condition? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 11. Have you ever had an adverse reaction to a cosmetic product or ingredient? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 12. Have you ever had an adverse reaction to a skin care treatment? If the answer is yes, please describe. | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> | | |
| 13. What are your skin concerns and challenges? | | |
| <hr/> | | |
| 14. What are you currently using on your skin? | | |
| Daytime | <hr/> | |
| Evening | <hr/> | |
| Weekly / Special Treatments | <hr/> | |
| 15. My esthetician may choose to use surface peeling products during my facial and I give consent. | | |

Client Signature

Date

SKINREADING REVIEW

2nd visit:

 Date

3rd visit:

 Date

4th visit:

 Date

PROFESSIONAL SKIN CARE

SKIN TYPE

<input type="checkbox"/> Very Dry	<input type="checkbox"/> Dry	<input type="checkbox"/> Combination	<input type="checkbox"/> Oily	<input type="checkbox"/> Very Oily	<input type="checkbox"/> Acne	<input type="checkbox"/> Sensitive
<ul style="list-style-type: none"> • No t-zone oil is present • Pores appear invisible • Thin and fragile skin texture 	<ul style="list-style-type: none"> • Very minimal t-zone oil is present • Has a few visible pores on the nose • Thin textured 	<ul style="list-style-type: none"> • Moderate t-zone oil is present a few hours after cleansing • Has visible pores in the t-zone • Clogged pores may be present 	<ul style="list-style-type: none"> • Wide t-zone gets oily within a few hours after cleansing • Visible pores on t-zone and cheeks • Clogged pores are present 	<ul style="list-style-type: none"> • Entire face gets oily shortly after cleansing • Many large visible pores on t-zone and cheeks • Many clogged pores are present 	<ul style="list-style-type: none"> • Pores are clogged (blackheads/whiteheads) • Skin has multiple breakouts • May have visible inflammation and redness 	<ul style="list-style-type: none"> • Skin appears flushed or red • Skin may appear flaky and dry • Skin may form red blotches when touched

CONCERNS

Eyes

- | | | |
|---|--|---|
| <input type="checkbox"/> Crows feet (CF) | <input type="checkbox"/> Sagging lids (SL) | <input type="checkbox"/> Puffiness (P) |
| <input type="checkbox"/> Undereye bags (UB) | <input type="checkbox"/> Dark circles (DC) | <input type="checkbox"/> Crepey skin (CS) |

Lips

- | | | |
|--|--|--|
| <input type="checkbox"/> Dry lips (DL) | <input type="checkbox"/> Peeling lips (PL) | <input type="checkbox"/> Vertical lines (VL) |
|--|--|--|

Skin

- | | | |
|--|---|---|
| <input type="checkbox"/> Aging skin (AS) | <input type="checkbox"/> Environmentally stressed skin (ES) | <input type="checkbox"/> Breakouts (B)
<i>Papules</i>
<i>Pustules</i> |
| <input type="checkbox"/> Lines (L) | <input type="checkbox"/> Flakiness (F) | <input type="checkbox"/> Post-acne dark spots (PA) |
| <input type="checkbox"/> Surface wrinkles (SW) | <input type="checkbox"/> Neck creases (NC) | <input type="checkbox"/> Scarring (S) |
| <input type="checkbox"/> Poor elasticity (PE) | <input type="checkbox"/> Sagging neck (SN) | <input type="checkbox"/> Pigmented spots (PS) |
| <input type="checkbox"/> Dehydration (D) | <input type="checkbox"/> Enlarged pores (EP) | <input type="checkbox"/> Redness (R) |
| <input type="checkbox"/> Dull skin (DS) | <input type="checkbox"/> Excess oil (EO) | <input type="checkbox"/> Visible capillaries (VC) |
| <input type="checkbox"/> Smoker's skin (SS) | <input type="checkbox"/> Clogged pores (CP)
<i>Blackheads</i>
<i>Whiteheads</i> | |



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&
marine
BRETANIA

PROFESSIONAL SKIN CARE