JS Advanced Skincare & Spa

Skin Evaluation Form

Name_____ Date_____

Welcome!

Our goal is to deliver the most pleasurable spa experiences… In order to customize your experience and assure your satisfaction and safety, please complete the questions below. The Spa's professional team will deliver the best spa experience possible and fulfill all your needs.

Email_____

Address_____

Sex: M / F City:_____

State_____ Zip Code_____

Home: ( ) Work: ( )

Cell: ( )

Date of Birth_____ Age_____

Emergency Contact:_____

Phone #: ( )

Allergies_____

How did you hear about us?

_____

Please put a check mark next to the procedures about which you would like to receive more information:

-Acne Treatment___ -Brown Spots/Sun Damage__

-Wrinkle Prevention___ -Seborrheic Keratosis___

-Facial Redness___ -Broken Capillaries___

-Enhanced Skin Rejuvenation___ -Spray Tanning___

-Warts, Skin tag, Skin Growth Removal__

-Skin Toning or Pore Size Reduction____

Please put a check mark next to a past/current medical condition

MEDICAL HISTORY

-Lupus or other auto-immune deficiency___ -Herpes simplex or fever blister___

-Recent Pregnancy___ - Diabetes___

-Bleeding abnormalities___ - Epilepsy___

-Treatment with Accutane___ -Scars that turn white or brown___

-Keloid or very thick scarring___ -Dark spots after pregnancy/injury___

-Psoriasis or Vitiligo___ - HIV/AIDS___

-Pulmonary embolism/blood clot___ -Hepatitis___

-Leg ulcer or Phlebitis___ -Waxing/Plucking/Electrolysis___

-Blood thinning medication___ -Transplant Anti-Rejection Drugs___

-Rheumatoid Arthritis "Gold" Therapy___ -Cystic Acne___

-Chemical Peels, Dermabrasion, laser Resurfacing or Face Lift___

Skin Evaluation Form Page 2

Please answer the following:

-You skin type is: Dry ( ) Normal/Combination ( ) Oily ( ) Acne Prone ( ) Sensitive ( ) Rosaceous Prone ( )

-Do you have a history of any of the following?

Skin Disease ( ) Cold Sores/Herpes on face ( ) Skin Allergies ( ) Eczema ( ) Other ( )

Explain:_____

-List all allergies:_____

-Have you used an Alpha Hydroxy or Salicylic Acid Products?YES ( ) NO ( )

-Do you use?: Retin-A ( ) Differin ( ) Azelex ( ) Renova ( ) Tazarac ( )

If yes, when was the last time you used this?

_____

-What brand(s) of cosmetic products do you currently use most?

_____

-Have you had previous face peels? YES ( ) NO ( )

If yes, when? What type?

_____

-Have you ever used Accutane? YES ( ) NO ( )

If yes, when?

_____

-Are you pregnant or actively trying to become pregnant? YES ( ) NO ( )

-Do you have any other areas you would like to treat? (Ex: hands, chest, neck, etc.)

Please Explain:

_____

-Do you use sunscreen? Daily ( ) Occasional ( ) Only for Outdoor Use ( ) Face SPF ( ) # Body SPF ( ) #

-Please list your current at home skincare regimen:

_____

-***Please list any medications or herbal supplements that you are currently taking:***

_____

What are some of your main Body Skin concerns?

-Muscle Tension___ -Stress___ -Discomfort___

-Dry Skin___ -Oily Skin___ -Cellulite___

-Sunburned___ -Arthritis___ -Loss of Elasticity & Firmness___

-Dehydration___ -Circulation___

Desired Massage Pressure: Light___ Medium___ Firm___ Deep Tissue___

Patient Signature:

_____

Date:_____