

Kingwood
Skin Essentials
Client Information

Please answer the following questions so that your Skincare Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skincare Specialist to accurately analyze and assess your skin care needs.

Name: _____ Date: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Date of Birth: _____ Sex: _____

E-mail address: _____

Who referred you to our Spa?

HIPAA PRIVACY STATEMENT

All patients have the right to have confidential care provided. All information, medical or social, whether written, spoken or electronic, or computer generated is held in strict confidence (please refer to the Care For Women/Kingwood Skin Essentials Compliance Privacy Rules Notice).

PATIENT RECORD OF DISCLOSURES

Please list any Emergency Contact we may speak to about your Medical information if you are unable to be reached timely.

Name: _____

Phone# _____

Patient Acknowledgement

Your signature below acknowledges that you have received the above HIPAA Privacy Notification regarding your rights to confidential care.

Signature: _____ Date: _____

Client Signature

Date

Credit Card Type & Number

Exp. Date

Billing Zip Code

Patient Profile

What skin conditions do you want to improve? _____

When exposed to the sun do you:

- _____ Always burn, never tan
- _____ Always burn, sometimes tan
- _____ Sometimes burn, sometimes tan
- _____ Always tan

Do you feel your skin is sensitive? Yes _____ No _____

Sun Protection:

Do you use a sunscreen? Yes _____ No _____

Do you tan in a tanning booth? Yes _____ No _____

Have you tanned in a tanning booth in the last 14 days? Yes _____ No _____

Have you had any direct sun exposure in the last 10 days? Yes _____ No _____

Prescription products:

- _____ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
- _____ Adepalene (Differin®)
- _____ Tazarotene (Tazorac®)
- _____ Isotretinoin (Accutane)

Any other topical antibiotics _____

Please List any allergies: _____

Home Care:

What skincare products are you currently using at home?

Please check if you are presently experiencing or have experienced any of the following:

- _____ Skin Cancer
- _____ Dermatitis
- _____ Keloid Scarring
- _____ Acne
- _____ Rosacea
- _____ Broken Capillaries
- _____ Treatment Reactions
- _____ Hypopigmentation/ Hyperpigmentation

Are you currently taking any medications including supplements? Yes _____ No _____

If yes, please list

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). I understand I need to sign this waiver prior to every treatment provided, with ANY changes pertaining to the above questionnaire.

Client Signature: _____ **Date:** _____

- Please check if permission is granted to use pictures for marketing and training purposes; your name will remain anonymous.