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: