NATURAL HEALTH & HEALING CENTER
CONFIDENTIAL SKIN HEALTH QUESTIONNAIRE

PATIENT/CLIENT INFORMATION

DATE:______________________

NAME:____

ADDRESS:_____________________________________

CITY/STATE/ZIP:_______________________________

HOME PHONE:_________________________________

WORK PHONE:_________________________________

CELL PHONE:__________________________________

EMAIL:____

OCCUPATION:__________________________________

REFERRED BY:__________________________________

MEDICAL INFORMATION

DATE OF BIRTH:_________AGE:_____FAMILY DR.:____________

DO YOU SMOKE?_____ HOW OFTEN?______LIVING W/SMOKER?____

HAVE YOU BEEN TREATED FOR: (PLEASE CIRCLE)

ACNE DEPRESSION SKIN DISEASE HIGH BLOOK PRESSURE

COLD SORES DIABETES CANCER

LIST OF ALL ALLERFIES/ALLERGIC:__________________________________

LIST OF ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:_______

____

ARE YOU PREGNANT?_________ TRYING TO GET PREGNANT?_________

HORMONE THERAPY?________ ARE YOU PRONE TO COLDSORES?_____

PERSONAL INFORMATION

CIRCLE YOUR CURRENT LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

CIRCLE YOUR NORMAL LEVEL OF STRESS: 1 2 3 4 5 6 7 8 9 10

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _________ DO YOU TAKE SUPPLEMENTS/VITAMINS?________________

DO YOU EXERCISE? _____ IF SO, HOW OFTEN?________ YOUR LAST SUNBURN?_________ DO YOU USE TANNING BEDS?_______

WHEN YOU GO OUT INTO THE SUN, DO YOU (CIRCLE ONE)

ALWAYS BURN(I) USUALLY BURN(II) SOMETIMES BURN(III) RARELY BURN(IV) VERY RARELY BURN (V) NEVER BURN(VI)

HAVE YOU EVER BEEN UNDER THE TREATMENT PLAN OF A

DERMATOLOGIST PLASTIC SURGEON ESTHETICIAN WOULD YOU BE INTERESTED IN COSMETIC SURGERY?

IF YES, WHAT PROCEDURE?____

ARE YOU CONCERNED ABOUT SKIN CONDITIONS ON YOUR BODY? (CHECK ALL THAT APPLY) SUN SPOTS SKIN LAXITY DRY/ROUGH

WHAT SKIN LINE ARE YOU CURRENTLY USING?____

DO YOU USE A DAILY ENVIRONMENTAL PROTECTION PRODUCT (SUNBLOCK)?______ IF NOT, WHY?________________________

CIRCLE HOW YOU FEEL ABOUT THE OVERALL QUALITY OF YOUR SKIN: (BAD) 1 2 3 4 5 6 7 8 9 10 (FANTASTIC)

YOUR SKIN TYPE IS (PLEASE CIRCLE ONE): NORMAL DRY/DEHYRDRATED REDUCTION OF BROWN SPOTS/SUNDAMAGE

IN ORDER OF IMPORTANCE, PLEASE RANK 1 (MOST IMPORTANT) TO 5 (LEAST IMPORTANT) IMPROVEMENT IN THE NEXT 30 DAYS:

REDUCTION OF FINE LINES ACNE SCARS DIMINISHED REDUCTION OF BROWN SPOTS/SUN DAMAGE

REDUCTION OF REDNESS REDUCTION OF OIL/ACNE

THANK YOU FOR COMPLETING THIS CONFIDENTIAL QUESTIONNAIRE.

THIS INFORMATION WILL ALLOW YOUR PROFESSIONAL SKIN CARE SPECIALIST TO PROVIDE THE OPTIMUM IMAGE PRODUCTS AND SERVICES

SIGNATURE:____ **DATE:**________________________________

PLEASE PRINT NAME: ____

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IF A MINOR, I AUTHORIZE ____ **TO PERFORM THE** ________________________ **ON**

____ **(NAME OF MINOR) DATE:**__________________________________

SKINCARE PRACTITIONER SIGNATURE: ____ **DATE:**_____________________________
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