

**At Last...Salon & Day Spa
185 Park Row
Brunswick, Maine 04011
207-373-0751**

TEEN Facial Client Questionnaire

Name _____ Today's Date _____
 Address _____ City _____
 State _____ Zip _____ Date of Birth _____
 Phone Home _____ Work _____

Do you wear contacts? Yes _____ No _____

If you have an active cold sore it is not recommended to receive a facial.

Skin Care Questions

What products are you currently using?

For your face

What type of shampoo/conditioner

A		A	
B		B	
C			
D			

Lifestyle Questions

Do you smoke? _____ Do you exercise regularly? Yes _____ No _____

If so, how often? _____ If so, how often? _____

What is your stress level? Low _____ Moderate _____ High _____

Are you currently on a restricted diet? Yes _____ No _____

List all medications and vitamins you take on a regular basis, and reasons for use:

Circle any of the following health problems you have had in the past or have currently:

- | | | |
|----------------------------------|-------------------|---------------------|
| Allergies | Asthma | Headaches - chronic |
| Heart Problems | Hepatitis | Psoriasis |
| External / Internal Cancer | HIV | Eczema |
| Diabetes | Epilepsy | Sinus Problems |
| High/Low blood pressure | Hormone Imbalance | Pacemaker |
| Herpes Simplex (i.e: cold sores) | Skin diseases | |
| Metal bone, pins or plates | Other: _____ | |

Are you allergic to:

Aspirin	Shellfish	Lactose	Aloe Vera
Latex	Nuts	Benzyl Peroxide	Sulfur

Do you have any open sores or abrasions? Yes _____ No _____

Have you had any cosmetic surgery in the past three months? Yes _____ No _____

If yes, what type? _____

Have you been under a physician's care in the past year? Yes _____ No _____

Female clients only

Are you currently taking oral contraceptives? Yes _____ No _____

Are you pregnant? Yes _____ No _____

Is your menstrual period due within the next week? Yes _____ No _____

General Questions

What is bothering you about your skin? _____

Do you touch your face a lot? _____ (such as; resting your chin on your hand)

How often do you change your pillowcase? _____

Do you have pets? _____ If yes, do they sleep on your pillow with you?

Do you play sports? _____ If so, what type?

Circle how you feel about the overall quality of your skin:

1 (bad) 2 3 4 5 6 7 8 9 10 (fantastic)

Skin Sensitivity Level

When you go in 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)

Do you feel your skin is sensitive to certain products? Yes _____ No _____

Have you ever used Retin A? Yes _____ No _____

Have you ever used the acne drug Accutane? Yes _____ No _____

If so, how long have you been off of it? _____

Skin Type

You feel your skin type is?: (circle only one)

Normal

Dry/Dehydrated

Oily

Acne / Acne Prone

Rosacea

Do you ever experience skin breakouts? Yes _____ No _____

If so, how frequently? _____

Do you pick at any acne that you might have? _____

Skin Moisture / Hydration Level

How much plain water do you drink a day? _____

Do you use a sun-protection when outdoors? Yes _____ No _____

Anything else we should know about you?

I understand that the services offered are not a substitute for medical care. I understand that the information herein is to aid the therapist in giving better service and is completely confidential. Professional consultation is required before initial dispensing of products. We require a 24 hour cancellation notice.

I fully understand and agree to the above salon policies.

Parent Signature

Date