DERMAVIDUALS® BASED ON CORNEOTHERAPY

CLIENT QUESTIONAIRE

The information you provide is completely confidential and used only for analysis.

NAME: **DATE:**

Address: ______________________ **City/State/Zip:** ______________________.

Phone: ______________________ **Work/Cell:** ______________________.

Email: ______________________ **Referred by:** ______________________.

Your Age is:

O under 19 **O** 19-25 **O** 26-35 **O** 36-45 **O** 46-59 **O** 60+

Your Sex is: **O** Female **O** Male

1. Which of the following most closely describes your skin tone:

   O Very Fair, burns easily, never tans, freckles (typically red hair)

   O Light, burns first, then tans (typically blond hair)

   O Light Olive, sometimes burns (typically light to medium brown hair)

   O Medium Light, rarely burns (typically Asian or Hispanic)

   O Dark Brown, never burns (typically African-American)

2. Which of the following best describes your skin type:

   O Very Oily Skin, large pores

   O Oily Skin

   O Combination Skin, only in the T-zone, dry/normal cheeks

   O Normal Skin

   O Dry Skin, small pores

3. Does your skin break out?

   O Almost Always **O** Frequently **O** Rarely **O** Never

4. How would you describe your skin?

   O Sensitive **O** Resilient **O** Not Sure

5. Do you have small, red, broken blood vessels on your face? **O** Yes **O** No

6. Have you ever seen a dermatologist for your skin? **O** Yes **O** No

   If yes, explain ____.

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7. Are you presently under a doctor's care? **O** Yes **O** No

   If so, why?____.

8. Are you currently taking any prescription or over the counter medications? **O** Yes **O** No

   List all oral medications you are taking____.

9. Do you or have you ever used:

   Tranquilizers?___ Antibiotics?____ Diuretics?____ Birth Control or Hormones?____ Antidepressants?____

   Steroids?_____Allergy?_____Medications?_____Explain:____.

10. Do you smoke? **O** Yes **O** No

11. Do you use Retin-A? **O** Yes **O** No

12. Do you currently or have you ever used the acne drug, Accutane? **O** Yes **O** No

13. Do you follow a restricted diet? **O** Yes **O** No

14. Do you have allergies to any of the following? (Check all that apply).

    O Aspirin **O** Retin-A **O** Hydroquinone **O** Alpha Hydroxyacids

    O Beta Hydroxyacids **O** Fragrances **O** Hydrogen Peroxide

FACIAL SURGERY

15. Have you had laser resurfacing or facial plastic surgery in the past 6 months? **O** Yes **O** No

16. Are you planning to have facial resurfacing soon? **O** Yes **O** No

17. Are you planning to have eyelid surgery soon? **O** Yes **O** No

18. Are you planning to have other facial Plastic Surgery soon? **O** Yes **O** No

PREVIOUS TREATMENT HISTORY

O AHA/Skin Peeling Treatment
O Microdermabrasion
O Laser Light Therapy
O Radio Frequency
O Ultrasound
O Micro Current

FEMALE CLIENTS ONLY

19. Are you taking oral contraceptives? **O** Yes **O** No

20. Are you currently pregnant, trying to become pregnant, or lactating? **O** Yes **O** N

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MALE CLIENTS ONLY

21. What is your current shaving system? **O** Wet **O** Electric
22. Do you ever experience irritation from shaving? **O** Yes **O** No
23. Do you experience ingrown hair? **O** Yes **O** No

WHAT KIND(S) OF RESULTS ARE YOU LOOKING FOR? (CHECK ALL THAT APPLY)

O Anti-oxidants; free radicals
O Age-Defying (diminish fine lines & wrinkles)
O Whitening/Depigmentation – lighten “age” spots
O Improve skin tone (radiance & hydration)
O Improve skin texture
O Dark Circles under eyes
Does anyone (blood relative) have dark circles under their eyes? **O** Yes **O** No
O Acne/Congested Treatment: O decrease oiliness; O blackheads; O minimize pore size.
O Anti-inflammatory/Anti-redness
O Dehydration, especially after Chemo and Radiation Treatments
O Atopic Dermatitis (Eczema)
O Seborrheic Dermatitis

23a. Please list any allergies or additional concerns that you might have:

____

____

24. Do you currently use a regular skin care routine? **O** Yes **O** No
25. What skin care products are you currently using? ______________________________________.
26. What type of a cleanser are you using:

O soap **O** gel **O** lotion **O** cream

27. Does anyone in your family (blood relatives), mother, father, grandparents have Rosacea?

O Yes **O** No

Client Signature____Date____________________________

Print Name____

Signature of Technician____

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Additional Notes:

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