



LASTING IMAGE FACE & BODY

LAST NAME FIRST NAME BIRTHDATE

ADDRESS CITY STATE ZIP

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HOME PHONE CELL PHONE BUSINESS PHONE / EXT.

DATE OF VISIT EMAIL ADDRESS

Referred by: ☐ Doctor ☐ Family ☐ Friend ☐ Patient ☐ Paper ☐ Phonebook ☐ Other _____

NAME OF REFERRAL SOURCE

ADDRESS OF REFERRAL SOURCE (SO WE CAN SEND A THANK YOU NOTE)

For better service we greatly appreciate your letting us know if there are any problems with service and/or products.

Do you have any of the following health issues? (Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Retina-A | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Nail fungus/athlete's foot | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Hormonal problems | <input type="checkbox"/> Sun exposure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rashes/hives |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Tanning | <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Excessive hyperpigmentation |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Cold Sores/Fever blisters | <input type="checkbox"/> Smoke | |

List medications: _____

List surgeries: _____

Pacemaker, implants, pins: _____

List allergies: _____

List frequently consumed foods: _____

Regularly ingest kelp, seaweed, salt? (circle)

List frequently consumed fluids: _____

List vitamin supplements: _____

Is elimination regular? ☐ Yes ☐ No

Women: Is your cycle regular? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Are you receiving dermatology treatment? ☐ Yes ☐ No

Products/medications prescribed: _____

☐ Acutane ☐ Antibiotics ☐ Retina A ☐ Renova

What are your concerns and goals: _____

Have you ever had a negative reaction to a cosmetic product?

If so, which product/ingredient? _____

How do you care for your skin? (specify brand name)

Cleanser: _____ Moisturizer: _____

Toner: _____ Scrub: _____

Mask: _____ Other: _____

Men: What do you use to shave with? _____

Do you experience problems with shaving? _____

What treatments are you getting for face and body? _____

Age, skin condition, sun damage, products, etc. may impact my skin's response to treatments. Because of these variables, results are individual and not guaranteed.

HOME CARE RX:

Improvement/Goals

1. _____
2. _____
3. _____
4. _____

Product

1. _____
2. _____
3. _____
4. _____

Service

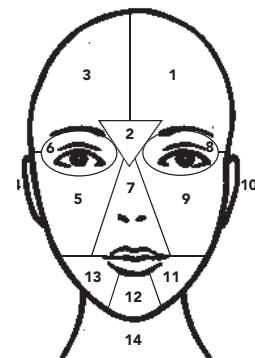
1. _____
2. _____
3. _____
4. _____

SKIN CONDITIONS

SKIN CONDITION	LOCATION OF EACH SKIN CONDITION					
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1. SENSITIZED

BURN Sun, Chemical, Wind, Heat	Mild	Mod	Severe	Neck	Back
TEMPORARY	Mild	Mod	Severe	Neck	Back
CHRONIC	Mild	Mod	Severe	Neck	Back
2. COMPRISED BARRIER	Mild	Mod	Severe	Neck	Back
3. DEHYDRATION	Mild	Mod	Severe	Neck	Back
4. EXCESSIVE DRYNESS	Mild	Mod	Severe	Neck	Back
5. ACNE LESIONS	Mild	Mod	Severe	Neck	Back
CYSTS	Mild	Mod	Severe	Neck	Back
NODULES	Mild	Mod	Severe	Neck	Back
PUSTULES Small Large (less than 5) (more than 5)				Neck	Back
PAPULES Small Large (less than 5) (more than 5)				Neck	Back



6. FOLLICULAR CONGESTION

MILIA	Mild	Mod	Severe	Neck	Back
COMEDONES OPEN	Resistive			Neck	Back
COMEDONES CLOSED	Large and Arrested			Neck	Back

7. TISSUE CONGESTION

Mild	Mod	Severe	Neck	Back
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8. UNEVEN TEXTURE

ROUGH	Mild	Mod	Severe	Neck	Back
FLAKY SKIN	Mild	Mod	Severe	Neck	Back

9. MATURING SKIN

FINE LINES	Mild	Mod	Severe	Neck	Back
LOSS OF ELASTICITY	Mild	Mod	Severe	Neck	Back

10. IRREG PIGMENTATION Hyper Hypo

Mild	Mod	Severe	Neck	Back
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11. CAPILLARY DISTENTION

Mild	Mod	Severe	Neck	Back
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12. ASPHYXIATED SKIN

Mild	Mod	Severe	Neck	Back
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13. HORMONAL IMBALANCE

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14. BODY

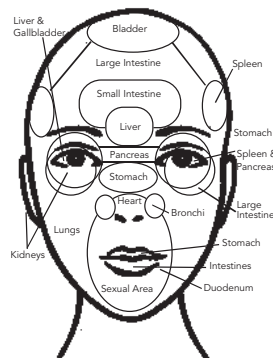
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15. ETHNIC BACKGROUND

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16. FITZPATRICK LEVEL

1 2 3 4 5 6



Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec

Chemical Peel Dermaplaning IPL LHR Filler Xeomin MicroPen Facial
Electrolysis MiroRoller Permanent Cosmetics (PM) Waxing Cosmetic Change (CC)