Esthetics Skillbook

Confidential Patient Information

Date _____

Name _____ Date of Birth _____

Address _____

_____

Email Address _____

Daytime Phone _____ Work Phone _____ Cell Phone _____

Your Occupation _____

Dermatologist _____ Phone _____ / Physician _____ Phone _____

Emergency Contact _____ Phone _____

Referred by Friend ❑ Newspaper Advertisement ❑ Mailer or Insert ❑ Other _____

Yes ❑ No ❑ Is this your first facial? Yes ❑ No ❑ body treatment? Yes ❑ No ❑ massage?

If not, when was your last facial _____ body treatment _____ massage _____?

What is the reason for your visit today? _____

What special concerns do you have? _____

Yes ❑ No ❑ Are you currently under a physician's care for any skin conditions?

If so, what condition specifically and for how long: _____

Yes ❑ No ❑ Have you had a recent operation? If so, please describe _____

Yes ❑ No ❑ Were any medications prescribed?

Yes ❑ No ❑ Are you still on medication?

Yes ❑ No ❑ If so, what kind? _____ What is the dosage? _____

Yes ❑ No ❑ Is the area of the operation still sensitive to different temperatures or amounts of pressure?

What is the date of your last gynecological visit? _____ Pap smear? Yes ❑ No ❑

Breast exam? Yes ❑ No ❑ Mammogram? Yes ❑ No ❑ Menstrual cycle? Yes ❑ No ❑

Yes ❑ No ❑ Are you pregnant? If so, how far along? _____ Are you (will you be) nursing? Yes ❑ No ❑

Yes ❑ No ❑ Are you taking birth control? If so, what kind and for how long? _____

Yes ❑ No ❑ Have you seen any changes in your skin since you started using it?

If you have, what changes have you seen? _____

Yes ❑ No ❑ Are you on hormone replacement therapy?

If so how has your skin adjusted to it? _____

Yes ❑ No ❑ Have you had any problems with moisture loss/becoming drier in any areas?

Date of last dental exam ___/___/___

Yes ❑ No ❑ Were dental x-rays required?

Yes ❑ No ❑ Do you wear contact lenses?

Yes ❑ No ❑ Do you smoke? If so, how much and how often? _____

Do you normally smoke inside ❑ or outside ❑?

If you DO NOT smoke, are you around smoke while at home ❑ or in the workplace ❑?

If yes, how often are you around it? _____

Yes ❑ No ❑ Do you have difficulty managing stress?

Yes ❑ No ❑ Do you or have you had cancer?

If so, what type and where? _____

When was it discovered? _____

When was your last treatment? _____

What kind of treatment was it? _____

Yes ❑ No ❑ Has anyone in your family ever been diagnosed with cancer?

If so, how are they related to you? _____

Are you using (or used): Azelex ❑ Differin ❑ Renova ❑ Retin-A ❑ Tazarac ❑ Accutane ❑

Glycolic or Alphahydroxy Acids ❑ If so, how long? _____

What are you using it for? _____

Yes ❑ No ❑ Have you noticed a difference? If so, what? _____

Yes ❑ No ❑ Do you have any concerns with the use of this product? If so, what? _____

Yes ❑ No ❑ Do you have acne or experience frequent blemishes? How frequently: _____

Yes ❑ No ❑ Do you have any allergies? If so please list: _____

Yes ❑ No ❑ Are you taking allergy medications? If so please list: _____

Yes ❑ No ❑ Are you taking any medications not listed above? If so, please list: _____

What products do you presently use for face & body? Soap ❑ Cleanser ❑ Toner ❑ Scrub ❑

Moisturizer ❑ Mask ❑ Sunscreen ❑ Other: _____

What brand/line are these products? _____

How do these products seem to be working for you? _____

How often do you use these products? _____

What is the SPF in any sunscreens you may be using? _____

Do you take: Fish Oil ❑ Flax Seed ❑ Multivitamin ❑ Energy-Enhancing Supplement ❑

If so, what kind and how often? _____

Yes ❑ No ❑ Have you noticed a difference in anything? _____

Daily water consumption? None ❑ 1-4 glasses ❑ 5-8 glasses ❑ More than 8 ❑

Daily caffeine consumption? None ❑ 1-2 cups of coffee ❑ 1-2 cans of soda ❑ ...or more ❑

How often do you exercise? Never ❑ daily ❑ 2-3 times a week ❑ weekends only ❑

Please check if you are affected by or are currently experiencing any of the following:

Anemia ❑	Cortisone treatments ❑	High blood pressure ❑	Respiratory disease ❑
Arthritis ❑	Diabetes ❑	Immune Disorders ❑	Shortness of breath ❑
Asthma ❑	DVT or Phlebitis ❑	Jaw pain ❑	Sinus problems ❑
Back problems ❑	Eating Disorder ❑	Kidney disease ❑	Skin diseases ❑
Bleeding gums ❑	Eczema ❑	Liver disease ❑	Skin rash ❑
Blood disorders ❑	Epilepsy ❑	Lupus ❑	Swelling of feet or ankles ❑
Broken Bones ❑	Fever blisters ❑	Metal pins or plates ❑	Thyroid problems:
Bruise Easily ❑	Headaches ❑	Nervous problems ❑	Hyperthyroid ❑
Cardiac problems ❑	Hemophilia ❑	Numbness ❑	Hypothyroid ❑
Chemotherapy ❑	Hepatitis ❑	Pacemaker ❑	Ulcer ❑
Circulatory problems ❑	Herpes ❑	Psychological problems ❑	Urinary/kidney problems ❑
Claustrophobia ❑	HIV/AIDS ❑	Radiation treatments ❑	Varicose Veins ❑

Please explain any of the above, including treatments or any significant others not mentioned: _____

_____

_____

_____

_____

_____

_____

_____

Please check any known allergies:

Aspirin ❑ Barbiturates ❑ Codeine ❑ Iodine ❑ Local anesthesia ❑ Penicillin ❑ Sulfur ❑ Other ❑ _____

I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I further understand that the information herein is to aid the esthetician in giving the most appropriate and safe treatment available and remains confidential.

Client Signature _____ Date _____

Consent to administer treatment for Minor/Dependent: Parent/Guardian _____ Date _____

Esthetician: _____ Makeup Artist: _____ Massage Therapist: _____

Hair Removal Technician: _____ Client comfort level: Sensitive ❑ Hot ❑ Cold ❑

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Facial Assessment (women)

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Date _____

Name _____

Skin Analysis 1 (Magnifying Lamp)

Skin Type Normal ❑ Dry ❑ Oily ❑ Combination ❑

Skin Texture Thin ❑ Medium ❑ Thick ❑

Moisture Level Lowest ❑ Low ❑ Medium ❑ High ❑ Highest ❑

Skin Analysis 2 (Wood's Lamp)

Muscle Tone Good ❑ Fair ❑ Fallen ❑

Pigmentation Hyperpigmentation ❑ Hypopigmentation ❑

Birthmarks ❑ Some Freckling ❑ Heavy Freckling ❑

Lines Deep Wrinkles ❑ Superficial Lines ❑

Crow's Feet ❑ Expression Lines ❑

Skin Sensitivity Normal ❑ Hypersensitive ❑ Hyposensitive ❑

Broken Capillaries

Nose Area Lowest ❑ Low ❑ Medium ❑ High ❑ Highest ❑

Cheek Area Lowest ❑ Low ❑ Medium ❑ High ❑ Highest ❑

Chin Area Lowest ❑ Low ❑ Medium ❑ High ❑ Highest ❑

Forehead Area Lowest ❑ Low ❑ Medium ❑ High ❑ Highest ❑

Entire face Lowest ❑ Low ❑ Medium ❑ High ❑ Highest ❑

Body Assessment (women)

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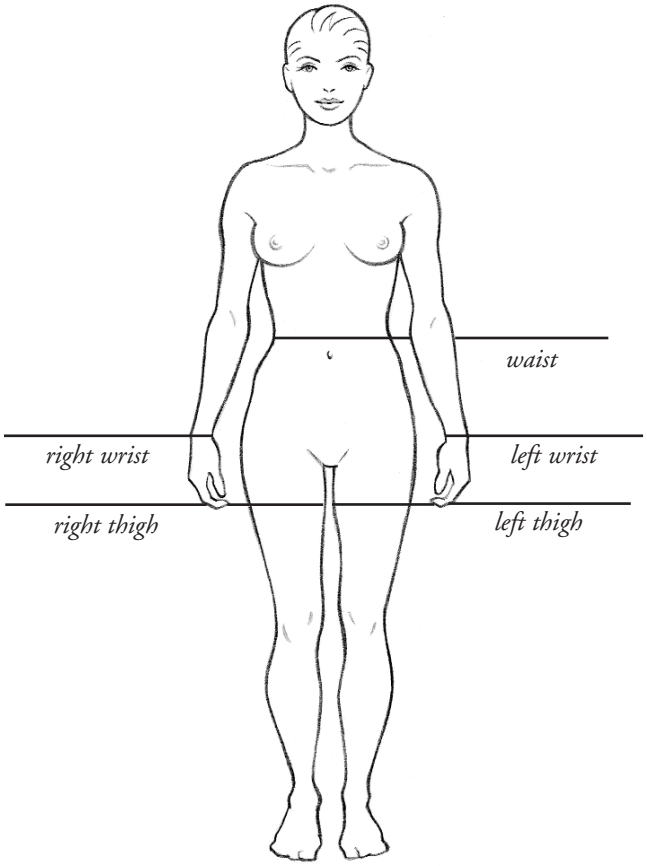
Lesions (Wood's Lamp and/or Dermascope)

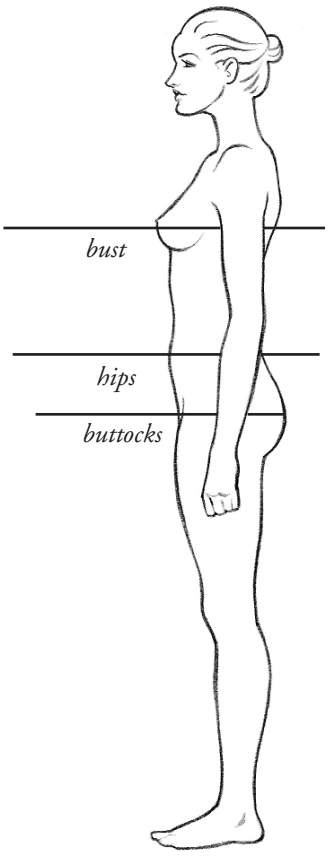
Macule ❑	Scale ❑	Plaque ❑	Spider Veins ❑
Vesicle ❑	Moles ❑	Fissure ❑	Telangiectasia ❑
Wheal ❑	Papule ❑	Haemangioma ❑	Comedone:
Crust ❑	Pustule ❑	Hypertrophy Scars ❑	Open ❑
Keloids ❑	Erythema ❑	Tumor ❑	Closed ❑
Lichenification ❑	Excoriation ❑	Cyst ❑	Other ❑
Patch ❑	Warts ❑	Milia ❑	_____
Bulla ❑	Nodule ❑	Fibroma ❑	_____

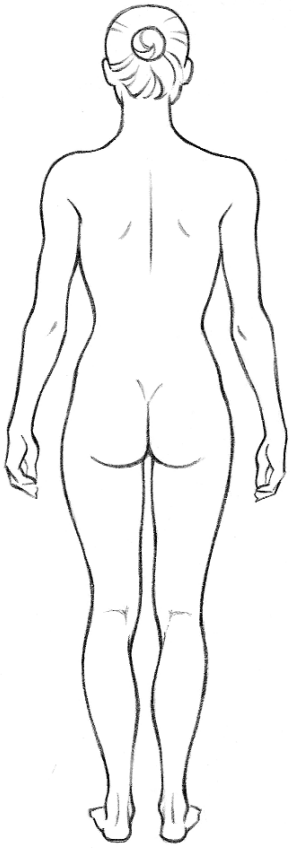
Other Conditions, Diseases and Disorders

Dehydrated Skin ❑	Atrophy ❑	Scar ❑	Adult Acne ❑
Hyperkeratinization ❑	Sun Damage ❑	Melonoma ❑	Ulcer ❑
Couperous Skin ❑	Keratosis/Keratoses ❑	Enlarged Pores ❑	Other ❑
Rosacea ❑	Sensitivities ❑	Seborrhea ❑	_____
Erosion ❑	Asphyxiated ❑	Irritation ❑	_____

Measurements and Indications Draw any posture faults and skin disorders, including moles, warts, bruises, dilated capillaries, varicose veins, etc. Use key to indicate Fat (+++), Cellulite (ccc), Poor Muscle Tone (ppp) and Stretch Marks (sss). List all measurements on the line provided.







Esthetics Skillbook

Patient Name: _____ **Follow Up Appointment:** _____

Mornings (AM)

1. Cleanser: *to remove product, dirt, oil, makeup.*
Dampen hands and apply product in upward and outward circular motion from the chin up. For men, upward and outward from the beard line above, downward and outward from the beard line below.

_____
_____
_____

2. Toner: *to balance ph.*

_____
_____
_____

3. Medication: *to correct skin conditions within the epidermis.*

_____
_____
_____

4. Serum: *to stimulate within the deeper layers of the epidermis (stratum spinosum, stratum basale and mucosom).*

_____
_____
_____

5. Moisturizer: *hydrates the upper layers of the epidermis (stratum corneum, stratum lucidum and stratum granulosum)*

Face _____
Eye _____
Lip _____

6. Sunblock: *Apply 20 to 30 minutes before going outside.*

7. Makeup

How To Apply:	Manual Exfoliate: upward circular motion
Liquid: spray	Chemical Exfoliate: apply for one minute, then rinse.
Pad: dab, wipe upward	
Brush: upwards movement	**Amounts:**
Serum: palm, sandwich, dab	Liquid: One drop
Cream: neck to forehead	Cream: Pea size
Powder: towards hairgrowth	Pump: 1 to 2 pumps

Evenings (PM)

1. Cleanser: *to remove product, dirt, oil, makeup.*
Dampen hands and apply product in upward and outward circular motion from the chin up. For men, upward and outward from the beard line above, downward and outward from the beard line below.

_____
_____

2. Toner: *to balance ph.*

_____
_____

3. Exfoliate: *to retexturize the epidermis.*

_____
_____
_____

4. Medication: *to correct skin conditions within the epidermis.*

_____
_____
_____

5. Serum: *to stimulate within the deeper layers of the epidermis (stratum spinosum, stratum basale and mucosom).*

_____
_____
_____

6. Moisturizer: *hydrates the upper layers of the epidermis (stratum corneum, stratum lucidum and stratum granulosum)*

Face _____
Eye _____
Lip _____

7. Mask: *specific treatment for the epidermis.*

_____

8. Target Area:

_____
_____
_____

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Esthetics Skillbook

Recommended Nutrition Plan

Before Breakfast

_____

_____

_____

_____

Mid-Day Snack

_____

_____

_____

_____

Breakfast

_____

_____

_____

_____

Dinner

_____

_____

_____

_____

Lunch

_____

_____

_____

_____

After Dinner

_____

_____

_____

_____

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