LOLA Glow

YOUR HOLISTIC SOLUTION TO SKINCARE

Date:_____

Name:_____ Date of Birth:_____

Address:_____

Home Phone:_____ Business Phone:_____

Cell Phone:_____ E-mail Address:_____

Single: ___No ___Yes Married: ___No ___Yes If Yes, Anniversary Date:_____

Employer:_____ Occupation:_____

Referred by:_____

What would you like to achieve from your treatment today?:_____

_____

Does your job require that you work outdoors?: ___No ___Yes Are you a smoker?: ___No ___Yes

Do you have any allergies?: ___No ___Yes

Are you currently under the care of a physician?: ___No ___Yes

If yes, for what conditions?:_____

Are you currently on any antibiotics, prescriptions, and/or topical prescriptions?: ___No ___Yes

Please list all medications taken (including supplements):_____

Do you have any metal implants in your body?: ___No ___Yes
Where?:_____

Do you have a pacemaker?: ___No ___Yes Have you ever experienced claustrophobia?: ___No ___Yes

Have you been treated for cold sores?: ___No ___Yes

Is there any medical reason you wouldn't be able to benefit from hot stone treatments?: ___No ___Yes

Do any essential oils bother you?: ___No ___Yes

Your daily stress level is: ___Mild/Low ___Average/Medium ___Intense/High

Have you ever had a facial treatment before?: ___No ___Yes
When?:_____

Have you ever had a body spa treatment before?: ___No ___Yes When?:_____

Massage	___No ___Yes
Salt Glow	___No ___Yes
Seaweed wrap	___No ___Yes
Moor mud	___No ___Yes
Body scrub	___No ___Yes

Other:_____

Do you or have you ever had any skin cancer?: ___No ___Yes Explain:_____

Do you have any special skin problems or concerns pertaining to your face or body?: ___No ___Yes

Specify:_____

Do you form thick or raised scars from cuts or burns?: ___No ___Yes

Have you ever had chemical peels, laser, or microdermabrasion?: ___ No ___Yes When:_____

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, or Retinol/vitamin A derivative products?: ___No ___Yes

Describe:_____

Have you used any of these products in the last 3 months?: ___No ___Yes

Have you used an acne medication?: ___No ___Yes When?:_____ Which drug?:_____

Do you use any products from Rodan and Fields?: ___No ___Yes

Are you currently using an exfoliant?: ___No ___Yes

What skin care products are you currently using (list brand if known)?:

Soap:_____ Shower Gels:_____

Toner:_____ Body Lotions:_____

Mask:_____ Sunscreen:_____

Eye Product:_____ SPF:_____

Cleanser:_____ Night Moisturizer/Cream:_____

Day Moisturizer:_____ Exfoliator:_____

Scrubs:_____ Other:_____

Makeup Products:_____

Have you recently used any self-tanning lotions, creams or treatments?: ___No ___Yes, specify:_____

Have You used any of the following hair removal methods in the past six weeks?: ___No ___Yes, check all that apply:

___Shaving ___Waxing ___Electrolysis ___Plucking ___Tweezing ___Stringing ___Depilatories

What areas of concern do you have regarding your:

Skin, check all that apply:

___ Breakouts/acne

___ Blackheads/whiteheads

___ Excessive oil/shine

___ Rosacea

___ Broken capillaries

___ Redness/ruddiness

___ Sun spot/liver spot/brown spot

___ Uneven skin tone

___ Sun damage

___ Wrinkles/fine lines

___ Dull/dry skin

___ Flaky Skin

___ Dehydrated

___ Other _____

Eyes, check all that apply:

___ Dehydrated

___ Wrinkles

___ Puffiness ___ Dark circles

___ Other _____

Lips, check all that apply:

___ Dehydrated ___ Cracked/chapped lips

___ Other _____

Have your had an allergic reaction to any of the following? (Check all that apply and explain):

___ Cosmetics ___ AHAs

___ Medicine ___ Fragrance

___ Food ___ Shellfish

___ Animals ___ Latex

___ Sunscreens ___ Drugs

___ Iodine ___ Pollen

___ Other _____

Explain:_____

_____

Have you ever had an adverse reaction after using any skincare product? (Check all that apply):

___ Rash ___ Irritation

___ Peeling ___ Sun sensitivity

___ Breakout ___ Other _____

What SPF do you use on your face?:_____ How often/when?:_____

What SPF do you use on your body?:_____ How often/when?:_____

Have you had any recent tanning bed or sun exposure that changed the color of your skin?: ___No ___ Yes

Specify:_____

Have you experienced Botox, Restylane or Collagen injections?: ___No ___ Yes

Specify:_____

Female Clients Only:

Are you taking oral contraceptives?: ___ No ___ Yes

Specify:_____

Any recent changes to or from your contraceptive treatment?: ___ No ___ Yes

Specify:_____

Are you Pregnant or trying to become pregnant?: ___ No ___ Yes

Are you nursing or planning to nurse?: ___No ___Yes

Are you lactating?: ___ No ___ Yes

Any Menopause problems: ___ No ___ Yes

Specify:_____

Male Clients Only:

What is you current shaving system?: ___ Wet shave ___ Electric

Do you experience irritation from shaving?: ___ No ___ Yes Ingrown hairs?: ___ No ___ Yes

Please use this space to complete answers where space was insufficient.

_____

_____

_____

_____

May I call/text you at your home, work, or cell phone number to confirm future appointments?: ___ No ___ Yes

May I contact you via email about future promotions and news?: ___ No ___ Yes

Client Signature:_____ Date:_____

If you are coming in for a facial appointment, please bring all of your current skincare products to your first visit so we can go over everything and be ready to relax!