LOVE SKINCARE CENTER
at Solera Salon and Spa

720.254.9234
8770 East Arapahoe Road
Centennial, Colorado 80112

Confidential Skin Health Survey

Date_____
First Name_____ Last Name_____ Middle Initial ____
Date of Birth_____
Street_____Apt_____
City_____ State_____ Zip_____
Phone-Home ( ) _____Work ( ) _____ Mobile ( ) _____
E-mail_____
Dermatologist/Physician_____ Phone ( ) _____
Emergency Contact_____ Phone ( ) _____
Your occupation_____
Referred by ___Friend ___Mailer___ Walk-in___ Yellow pages___Other

1. Is this your first facial treatment? ___Yes___No
2. What is the reason for your visit today? _____
3. What special concerns do you have? _____
4. Are you presently under a physician's care for any current skin condition or other problem? ___ Yes ___ No
5. Are you pregnant? ___Yes___No
6. Are you taking birth control pills? ___Yes___No If so, what type?_____
7. Hormone replacement? ___Yes___No If so, what type? _____
8. Do you wear contact lenses? ___Yes___No
9. Do you smoke? ___Yes___No
10. Do you often experience stress? ___Yes___No
11. Have you had skin cancer? ___Yes___No
12. Are you currently or have you in the past used:
    ___Azelex___Differin___Renova____
    ___Retin-A___Tazorac___Glycolic Acid___Salycilic Acid
    If so, when and for how long? _____
13. Are you currently or have you ever used Accutane? ___Yes___No
14. Do you have acne? ___Yes___No
    Experience frequent blemishes? ___Yes___No
    If so, how frequently? _____
15. Do you have any allergies to cosmetics, foods or drugs? ____Yes___No
    Please list_____
16. Are you presently taking oral or topical medications? ___Yes___No
    If so, please list: _____
17. What products do you currently use? ___Soap___Cleansing milk___Toner___
    ___Scrub___Mask___Creams___Sunscreen___Vitamin A___Vitamin C___ Other

18. Please circle the procedures are you interested in.

Botox	Make up consultation
Dermaplane	Microdermabrasion
Facial	Skincare consultation
Juvederm	Waxing

19. Please circle if you are affected by or have any of the following:

Asthma	Hepatitis	Metal bone, pins or plates
Cardiac problems	Herpes	Pacemaker
Eczema	High blood pressure	Sinus problems
Epilepsy	Hysterectomy	Skin diseases-other
Fever blisters	Immune disorders	Urinary or kidney
Headaches--chronic	Lupus	problems

Please explain above problems and list any significant others_____
_____

I understand that the services offered are not a substitute for medical care and any information provided by the aesthetician is for education purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid
the therapist in giving better service and is completely confidential.

Love Skincare Center, LLC. Policies:

1. A full twenty-four hour cancellation notice is appreciated to avoid a 50% service charge.

2. Love Skincare Center does not issue cash refunds.

3. To better serve you, an initial consultation is required before dispensing any product.

I fully understand and agree to the above policies.

Signature _____ Date_____