

Variations Corrective Skincare & Nurturing Oasis Consultation Intake Form

Last Name (Please Print): _____ First Name _____ Apt/Unit: _____

Street Address: _____

City: _____ State: _____ Zip _____

E-Mail Address: _____ @ _____

Telephone: home() _____ work() _____

Month & Day of Birth: ____ / ____ under 21 21-30 31-40 41-50 51-60 60+

Referred by: _____

ANCESTRAL HISTORY

National Origin/Race: African American Asian Caucasian Hispanic Jewish Other _____

Acne in family/parents: mother father sibling other relatives: _____

YOUR HEALTH

1. Within the last year, have you been under a physician's care? yes no
 2. Within the last year, have you been under a dermatologist care? yes no

Dermatologist name and number _____

3. Within the last nine months, have you undergone any surgery? yes no

If yes, please specify _____

4. Have you had or have you now any of these health problems? Lupus Sinus problems Anemia Raynaud's
 Cancer, if so, how long have you been free of cancer or cancer treatments? _____ Diabetes Epilepsy
 Heart problems Hypertension Hormone Imbalance Spinal Injury Claustrophobia Asthma
 Hysterectomy Thyroid condition Varicose Veins Systemic Disease HIV Positive Herpes Allergies
5. List any medications, supplements, vitamins, diuretics, slimming pills, etc. that you take regularly _____

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6. Do you smoke? yes no occasionally
 7. Do you exercise regularly? yes no occasionally
 8. Do you follow a restricted diet? yes no occasionally
 9. Do you have regular sleep patterns? yes no occasionally
 10. Do you wear contact lenses? yes no occasionally
 11. Do you have metal implants or a pacemaker? yes no
 12. How is your elimination? good fair poor
 13. What is your stress level? high medium low
 14. Have you had a reaction to any of the following? cosmetics medicine iodine pollen food shellfish

hydroxy acids animals fragrance sunscreens other _____

YOUR SKIN

15. Describe your skin type. normal oily dry combination (oily in T-Zone)

16. With what temperature of water do you cleanse? cool warm hot

17. Do you have any special areas of concern pertaining to your face or body? yes no

If yes, please specify _____

18. What skin care products are you currently using? soap cleanser toner/astringent moisturizer masque
 exfoliator eye care sunscreen others _____

19. What are the brand names of the products you currently use? _____

20. What make-up and hair products are you currently using? liquid foundation cake foundation stick foundation
cover-up loose powder pressed powder blushers oil sheen/braid spray hair/conditioner spray

21. Have you ever experienced acne breakouts? yes no

occasionally

Affected areas: face chest back upper arms other _____

EXFOLIATION AND BLEACHING HISTORY

22. Have you ever had chemical peels, laser, microdermabrasion or any resurfacing treatments?
yes no in last month yes
no

23. Do you use Accutane, Retin A, Renova, or Adapalene? yes no in last 3 months? yes no

24. Do you use an acne medication? yes no in last 6 months? yes no

If yes, which drug _____

25. Are you currently using any products that contain the following ingredients? Glycolic Acid Lactic Acid Salicylic Acid
exfoliating scrubs Hydroxy acid products Vitamin A derivatives (i.e. Retinol) Sulfur Cortisone
Cleocin-T

26. Have you ever used a bleach (Hydroquinone) or fade cream(Kojic Acid) or and Over-the-counter product?

Hydroquinone Kojic Acid Over-the-counter product name: _____

27. Did you experience an allergic reaction to the bleach or fade cream such as: swelling, itching or fine bumps? yes no

28. Are you using any topical medications that cause you to peel? yes no Product name: _____

MOISTURE HYDRATION

29. How much plain water do you consume daily? _____

30. How many alcoholic beverages do you consume weekly? _____

31. Do you ever experience these conditions on your skin? flakiness tightness obvious dryness

32. What season of the year do you have these experiences of dryness? summer spring winter fall all year

OIL SECRETION

33. Do you ever experience oily shine during the day? yes no occasionally

34. Is oil experience all over or on the T-Zone (forehead, nose and chin)? all over T-Zone

NERVE ACTIVITY

35. Do you drink caffeinated beverages (coffee, tea, soft drinks)? yes no occasionally
36. What type of massage do you prefer? soft medium firm
37. What is your pain threshold? low medium high

CAPILLARY ACTIVITY

38. Do you burn easily in moderate sunlight? yes no
occasionally
39. Do you blush easily when nervous? yes no
occasionally
40. Do you have a tendency to redness? yes no

FEMALE GUESTS ONLY

41. Are you taking oral contraception? yes no
42. Do you experience PMS breakouts? yes no
occasionally
43. Do you experience menstrual bloating or pain? yes no
occasionally
44. Are you pregnant or trying to become pregnant? yes no
45. Are you lactating? yes no
46. Do you experience ingrown hairs? yes no
occasionally
If so, where are they located? chin chest
face
47. Are you taking HRT or any hormone balancing products? yes no

MALE GUESTS ONLY

48. What is your current shaving system? single edge razor electric/rotary clipping or trimming only
49. Direction of stroke? upward downward both How often? _____

50. What shaving products are you currently using? _____

51. Do you experience razor bumps/ingrown hairs? yes no
occasionally
52. Do you experience neck bumps? yes no
occasionally

QUESTIONS TO DISCUSS EVERY VISIT

1. Are you currently having or due for your menstrual period? yes no
2. Have you started any new medications? yes no

If yes, what are they? _____

3. Have you had any recent dental x-rays?

yes

no

4. What are your skin or body care goals for today? _____

PAYMENT AGREEMENT, POLICY AND CANCELLATION PROCEDURES

In the event of a “no-show” you will be charged for half of the service at your next appointment. All forms of payment are accepted. Should you need to cancel, please extend the courtesy of 24 hours notification by calling 301-593-7671 to avoid a 100% charge of your treatment to your next service. I certify that all of the above information is true to the best of my knowledge AND I understand and agree with the payment, policy and cancellation procedures. By signing this form, I wave any and all claims, damages, action and liabilities against Variations Corrective Skincare and its Owner arising out of or relating to skincare and body care services, Image Enhancement (make-up), Hair Removal and Allergic Reactions to products, services and health supplements suggested and/or sold.

Signature: _____ Date: _____