SKINTHERAPY
SKINCARE & ACNE CLINIC

Pre-Treatment Questionnaire

Please open in Adobe Acrobat for full functionality.

Name:_____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Email: _____ Ethnicity: _____

Prescribed Medications, Over-the-Counter Medications and Recreational Drugs (past and present use):

Medications	Have Used	Using
Antibiotics	☐	☐
Accutane	☐	☐
Benzoyl Peroxide	☐	☐
Clindamycin Topical	☐	☐
Clindamycin Oral	☐	☐
Adapalene	☐	☐
Retin-A Cream/Gel	☐	☐
Tazorac	☐	☐
Differin	☐	☐
Azelex	☐	☐
Sulfur	☐	☐
Androstenedione	☐	☐
Cortisone	☐	☐
Minocycline	☐	☐
Copaxone	☐	☐

Medications	Have Used	Using
Testosterone	☐	☐
Progesterone	☐	☐
Disulfiram	☐	☐
Cyclosporine	☐	☐
Dilantin	☐	☐
Lithium	☐	☐
Thyroid Medication	☐	☐
Quinine	☐	☐
Isoniazid	☐	☐
Imuran	☐	☐
Danazol	☐	☐
Gonadotropin	☐	☐
Steroids	☐	☐
Recreational Drugs	☐	☐
Antidepressants	☐	☐

Please write the product name(s) you are currently using:

Cleanser: _____ Mask: _____

Toner: _____ Foundation: _____

Serum: _____ Blush: _____

Moisturizer: _____ Exfoliant (ex. Glycolic): _____

SPF: _____ Acne Medication: _____

Allergic Reactions:

Allergic reactions to any of the above products? ☐ Yes ☐ No

Are you allergic to? ☐ Sulfur ☐ Aspirin ☐ Latex

Any allergic reactions on your face? ☐ Yes ☐ No

If yes, what product? _____

Please describe:

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Medications	Have Used	Using	Medications	Have Used	Using
Antibiotics	☐	☐	Testosterone	☐	☐
Accutane	☐	☐	Progesterone	☐	☐
Benzoyl Peroxide	☐	☐	Disulfiram	☐	☐
Clindamycin Topical	☐	☐	Cyclosporine	☐	☐
Clindamycin Oral	☐	☐	Dilantin	☐	☐
Adapalene	☐	☐	Lithium	☐	☐
Retin-A Cream/Gel	☐	☐	Thyroid Medication	☐	☐
Tazorac	☐	☐	Quinine	☐	☐
Differin	☐	☐	Isoniazid	☐	☐
Azelex	☐	☐	Imuran	☐	☐
Sulfur	☐	☐	Danazol	☐	☐
Androstenedione	☐	☐	Gonadotropin	☐	☐
Cortisone	☐	☐	Steroids	☐	☐
Minocycline	☐	☐	Recreational Drugs	☐	☐
Copaxone	☐	☐	Antidepressants	☐	☐

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Please describe:

Lifestyle Considerations:

At what age did your acne start? _____

Do you get cold sores? ☐ Yes ☐ No

Use a Clarisonic? ☐ Yes ☐ No

Do you pick at your skin? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you use fabric softener? ☐ Yes ☐ No

Do you use fabric softener dryer sheets? ☐ Yes ☐ No

Do you work near chemicals, tars, oils or inks? ☐ Yes ☐ No

Are you under a lot of stress? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you on birth control? ☐ Yes ☐ No

If yes, what type?

- ☐ Depo Provera shots
- ☐ Hormonal IUD (Mirena, Skyla, Liletta)
- ☐ Non-Hormonal IUD (ParaGard)
- ☐ The Pill

If yes, what brand? _____

☐ estrogen/progestin combo ☐ progestin only

Do you regularly eat?

- ☐ Kelp
- ☐ Seaweed
- ☐ Sushi
- ☐ Salt
- ☐ Fast Food
- ☐ Milk
- ☐ Cheese
- ☐ Whey
- ☐ Soy
- ☐ Whey Protein Shakes
- ☐ Whey Protein Bars
- ☐ Soy Protein Shakes
- ☐ Soy Protein Bars
- ☐ Peanuts
- ☐ Peanut Butter

What are your skin care concerns?

- ☐ Blackheads
- ☐ Whiteheads
- ☐ Pimples/Pustules
- ☐ Cysts
- ☐ Oily Skin
- ☐ Dehdyrated Skin
- ☐ Dark Spots
- ☐ Age Spots
- ☐ Broken Capillaries
- ☐ Fine Lines/Wrinkles
- ☐ Dry, Flaky Skin
- ☐ Sensitive Skin
- ☐ Razor Bumps
- ☐ Shaving Irritation
- ☐ Acne Rosacea

Describe your skin:

- ☐ Oily
- ☐ Normal
- ☐ Dry
- ☐ Combination Oily/Dry
- ☐ Sensitive

Have you had any of the following skin services?

☐ Glycolic Acid Peel	Date: 12	31	_____	Anything else?
☐ Microdermabrasion	Date: 12	31	_____	
☐ Chemical Peel	Date: 12	31	_____	
☐ Skin Cancer Removal	Date: 12	31	_____	
☐ Plastic Surgery	Date: 12	31	_____	
☐ Laser Hair Removal	Date: 12	31	_____	
☐ Facial Waxing	Date: 12	31	_____	
☐ Electrolysis	Date: 12	31	_____	

Medical History:
Please check any condition you may have had in the past two years.

- ☐ Diabetes
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Thyroid Problems
- ☐ HIV + or AIDS
- ☐ Thrombosis/Blood Clot/Stroke
- ☐ Eczema
- ☐ Staph Infection or MRSA
- ☐ Surgical Metal Pins/Plates
- ☐ Psoriasis
- ☐ Hormone Problems
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Herpes Simplex/Cold Sores
- ☐ Hysterectomy/Ovary Removal
- ☐ Nursing
- ☐ High Blood Pressure
- ☐ PCOS
- ☐ Cancer
- ☐ Anemia
- ☐ Lupus

Are you under a dermatologist's care? ☐ Yes ☐ No **Name of Doctor:** _____

What kind of work do you do? _____

How did you hear about us? _____

What results would you like to obtain with your skin? _____

_____

SKINTHERAPY
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Clinic Policies and Cancellation Guidelines

Please review and sign our clinic policies and cancellation guidelines.

It is standard business practice to hold your appointment with a credit card number. We want to know that you are as serious as we are about helping you have clear skin. 24-hour cancellation or rescheduling notice is required. To cancel or reschedule you can log into the booking portal at www.acnetreatmentskincareslc.com or contact us by texting 801-800-6602. Our cancellation policy is strictly enforced. Cancellations without a 24-hour notice will be charged for the full appointment cost.

- ☐ **No Show:** You will be charged 100% of the appointment fee if you no show your appointment.
- ☐ **Cancellations or Rescheduling:** A 24-hour cancellation or rescheduling notice is required. Cancellations without a 24-hour notice will be charged the full appointment cost. Exceptions will be made for illness/family emergencies.
- ☐ **Illness:** If you become ill please text us at 801-800-6602 so we can reschedule.
- ☐ **Arriving Late:** Your treatment time will be shortened to fit into the time you have allowed. If you arrive more than 15 minutes late, your appointment is forfeited and you will be responsible for the full appointment fee.
- ☐ **Your Appointment is Your Responsibility:** While we offer email, text message, and phone reminders, failing to receive them or read them does not waive your responsibility for your appointment time. Parent/Guardian, you are responsible for your minor's appointment times and the fees they may incur for not attending them.
- ☐ **Please Leave Children/Siblings at Home:** We ask that you do not bring family members or young children with you to your appointments. If you are under 18 you must be accompanied by one parent/guradian. However, our office is small and cannot accommodate other siblings.
- ☐ **A Word About Prospective Young Clients (Ages 13-18):** We have found that teen cases can be more difficult due to the lack in motivation and consistency with our program guidelines. To achieve clear skin our clients need to be 100% consistent with their home care and lifestyle changes. Please understand these limitations and talk to your teen to make sure they can be 100% dedicated to the program before scheduling.
- ☐ **Health Insurance:** Our clinic does not process insurance claims or work with health insurance companies. We are skincare professionals and master estheticians, not doctors. All services and product purchases are self-pay and due at the time of service.
- ☐ **Additional Guidelines:**
  1. Please discontinue using any topical prescriptions prescribed for acne for two weeks prior to your appointment with us. (Retin-A, Differin, Clindamycin, Onexton, etc.)
  2. Do not use Accutane for at least three months prior to your appointment.
  3. We do use benzoyl peroxide in our program. Very few people are allergic to benzoyl peroxide, but if you have a known allergy we cannot treat you.
  4. All product and makeup sales are final. We will do our best to swap out product if there is an allergic reaction.

I _____ have read this document and understand and agree to the policies and guidelines set above.

Patient (Parent/Guardian) Signature: _____ Date: _____

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Acne Treatment Consent Form

An acne treatment may consist of surface cleansing, mild chemical peels or steam and exfoliation, application of antibacterial serums, corrective serums and extractions. Treatments take approximately 20 to 45 minutes to complete and are designed to balance, hydrate, clean acne impactions and prepare the skin for the home care regimen. Implements and equipment used in all this facility are disposable or properly sterilized according to the State Board of Cosmetology regulations.

IMPORTANT: please read carefully and acknowledge.

- ☐ I have not been exposed to excessive sun and my skin does not feel sensitive or irritated in any way.
- ☐ I have not had any other chemical peel of any kind, within 14 days of this treatment.
- ☐ I have not had any facial waxing, within seven days of this treatment.
- ☐ I have informed the clinic of all health problems of which I am aware of; *including herpes simplex/cold sores.*
- ☐ I have informed the clinic of any use of oral or topical medications I may be using including Retinoids (Retin-A, Renova, Avita, Differin, Tazorac, Tretinoin) or Accutane.
- ☐ I understand that controlling acne/problem skin is best achieved through a series of recommended treatments and compliance to the home care product program recommended by a certified Acne Specialist/Master Esthetician.
- ☐ I understand that I will probably not experience much visible peeling, flaking, discoloration or irritation following this procedure if I follow my homecare instructions carefully.

WARNINGS: please read carefully and acknowledge.

- ☐ Avoid direct sunlight for at least three days following a treatment.
- ☐ Tanning booths are prohibited while working with Skintherapy
- ☐ Use of sunblock protection of at least a SPF 30 is necessary following all treatments.
- ☐ Do not pick your skin following a treatment.

PRODUCT RETURN GUIDELINES: please read carefully and acknowledge.

- ☐ Skintherapy products are clinical-strength active formulas designed to treat problem skin conditions. Tingling sensations are normal with product application but should not be painful. If you are experiencing stinging and irritation with any product, stop using the product and text your esthetician for further instruction.
- ☐ Products may not be returned.

RESCHEDULING GUIDELINES AND LATE POLICY: please read carefully and acknowledge.

- ☐ A **24-hour rescheduling notice is required**. We realize emergencies happen and will be considered, but reserve the right to charge a **$75 fee** for missed appointments without a 24-hour notice. If you are more than 15 minutes late we cannot guarantee that we will be able to fit your appointment in. You may not be seen. If we cannot fit you in there will be a **$75 fee charged** for the missed appointment.

I, _____ , consent to photographs taken of my face to be used for monitoring treatment progress.

I, _____,hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-treatment care instructions as I am directed.

Patient (Parent/Guardian) Signature: _____ Date: _____

Esthetician Signature: _____ Date: _____

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SUBMIT FORM CLEAR FORM