



Skincare Intake Form

Patient Name _____ DOB ____/____/____ Date _____

Please fill in your skin type information as requested below.

Do you have sensitive skin on your face (easily irritated, breaks out in a rash in response to products)? (please circle) Never Sometimes Often Always

Do you have dry, normal, combination or oily skin?

- _____ Oily- skin which is often oily or greasy. A person with oily skin will feel "sticky" by late afternoon.
_____ Combination- skin which is sometimes dry and sometimes oily or dry in some areas and oily in others.
_____ Normal- skin which is neither dry nor oily most of the time.
_____ Dry- skin which is rough or gets mild flakes if a daily moisturizer isn't used and often feels tight after washing.

Yes / No Have you ever had a reaction to skincare products? If so, what type of products and what type of reaction developed?

Yes / No Are there skincare products that you have used that you feel were not effective? If yes, please describe:

Which products do you currently use? (please list specific brand & name of product and topical medications):

Table with 2 columns: AM and PM. Rows include: Cleanser, Toner, Scrub/Mask, Treatment/Serum, Moisturizer, Sunscreen, Eye Cream, Other.

If you do not wear sunscreen daily, how often do you use sunscreen and what SPF level?

Face _____ Body _____

Please check off your specific concerns as listed below. Rank those checked 1-10 rating your concern? (1 being the most 10 being the least)

- Moisturizing, face Moisturizing, body Anti-aging, face Anti-aging, body
Lightening Firming Acne Rosacea
Sun protection Pampering Healing Other

Notes: _____

See Skin Wizard Regimen Sheet _____ for recommended skincare program.

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