REVIVE
SKINCARE CLINIC

New Patient Skin & Health Questionnaire

Welcome to Revive Skincare Clinic! We are committed to providing you with unparalleled services and products. Please complete the following form as thoroughly as possible to help us achieve this goal. All information provided is kept confidential. Thank you for choosing Revive Skincare Clinic. It is our pleasure to serve you.

Name (please print)_____ DOB_____

Address_____ City_____ State/Zip_____

Preferred Contact Number_____ Email _____

May we add you to our email list? YES_____ No Thank You_____

Whom may we thank for your referral? _____

Skincare History

The following is essential is essential to optimize the results of your service:

Which concerns apply to your skin? Please check all that apply:

__Discoloration or Hyperpigmentation	__Fine Lines & Wrinkles	__Dry, Flaky Skin	__Oily Skin
__Acne/Breakouts	__Acne Scarring	__Enlarged Pores	__Rosacea
__Dilated Capillaries	__Redness (Reactive Skin)	__Uneven Texture	__Sun Damage
__Loss of Facial Contours	__Lax or Sagging Skin	__Dark Under-Eye Circles	__Skin Concerns in Neck Area
__Photodamaged Hands	__Unwanted Hair	__Stretch marks	

Please list any other concerns:

_____

_____

What type of skin do you think you have?

____Dry ____Normal ____Combination ____Oily

Do you have a history of acne? ____Yes ____No

If yes, are you using or have you ever used any medications for acne? ____ Yes ____No

Name of medication:_____

Do you sunbathe or participate in outdoor activities? ____Yes ____No

Have you ever had a reaction to any skincare product or cosmetic? ____Yes ____No

If yes, please list:_____

Please check the skincare products you currently use and their brand names:

__Cleanser: _____	__Toner: _____	__Exfoliant: _____
__Vitamin C Serum: _____	__Daily Moisturizer: _____	__Nighttime Moisturizer: _____
__Eye Cream: _____	__SPF: _____	__Other: _____

Please check if you are currently using any of the following:

__Retinol	__Glycolic Acid	__Lactic Acid	__Salicylic Acid	__Citric Acid
__Resorcinol	__Benzoyl Peroxide	__Hydroquinone	__Azelaic Acid	__ Retin A (Tretinoin)
__Topical Antibiotics	__Topical Steroids	__Isotretinoin		

Have you ever, or are you currently receiving skin services? ____Yes ____No

Have you had any of the following?

__Chemical Peel	__Laser Resurfacing	__Cosmetic Surgery	__Facial Injectables
__Permanent Cosmetics	__Light Treatments	__Microdermabrasion	__Dermaplaning

__Extractions	__Electrolysis	__Laser Hair Removal	__Waxing

General Health

Are you currently under the care of a physician? ____Yes ____No

If yes, please discuss any contraindications of any pre-existing medical conditions with your physician.

Are you currently taking any medications? ____Yes ____No

If yes, please list here: _____

_____

Do you suffer from any of the following (check all that apply):

__Dermatitis	__Eczema	__Psoriasis	__Open sores or lesions
__Cold sores/ Fever Blisters/ Herpes Zoster	__Actinic Keratosis	__Keloid Scarring	

Are you allergic to aspirin? ____Yes ____No

Do you have any drug allergies? ____Yes ____No

If yes, please list here: _____

_____

Female Clients

Are you on hormone replacement therapy? ____Yes ____No

Are you currently taking birth control? ____ Yes ____No

Are you currently pregnant, breastfeeding or planning on becoming pregnant? ___Yes ____No

Do you have any other medical conditions we should be aware of (i.e. diabetes, hypertension, epilepsy, etc.)?

If yes, please list here:_____

_____

All of the above information is true and accurate to the best of my knowledge. I take full responsibility for alerting my Physician/Aesthetician to any physical or mental condition which would affect my service or results. I understand my treatment is therapeutic in nature and will alert my Physician/Aesthetician to any discomfort.

(Initials_____)

Liability

I understand and acknowledge there are risks involved with the treatment of facials, peels, microneedling, microcurrent and laser skin treatments. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive Revive Skincare CLinic and the Physician/Aesthetician's liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results, complications or effects and herby waive Revive Skincare Clinic and the Physician/Aesthetician's liability if such results or complications occur. In consideration for Revive Skincare Clinic and the Physician/Aesthetician's performing this procedure, I agree I will assume the rick and full responsibility for any and all injuries, losses or damages, which might occur to me while I am undergoing this procedure or side effects I may experience after the procedure is performed. I understand that the Physician/Aesthetician does not diagnose illness, disease, or any other physical or mental conditions. Any Sexualmisconduct exhibited by the client will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against the Physician/Aesthetician, Revive Skincare Clinic, it's service providers, owners, officers, employees or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure. I agree this waiver and release shall bind the members of my family and any spouse or domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives, or assigns if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue Revive Skincare Clinic or any of it's service providers.

Revive Skincare Clinic's maximum aggregate liability to patient related to or in connection with the procedures performed by the Revive Skincare Clinic, it's employees or agents will be limited to the total amount paid to Revive Skincare Clinic by the patient for procedures performed by Revive Skincare Clinic Physician/Aesthetician.

_____	_____	_____
Client Signature	**Printed Name**	**Today's Date**
_____	_____	_____
Signature Parent/Guardian if under 18	**Printed Name**	**Today's Date**