Zen Retreat
Facial Questionnaire

Name: _____ Occupation: _____ Date: _____

Address: _____ City: _____ State: _____ Zip Code_____

DOB: _____ Age: _____ Email Address: _____

Home: _____ Cell: _____

How did you hear about us? _____

GENERAL HISTORY

Are you currently under a physician's care? □ Yes □ No
Have you undergone surgery in the last 9months? □ Yes □ No
If yes Specify: _____

Have you had any of the following conditions?
□ Cancer □Hormone Imbalance
□ Diabetes □ Hysterectomy
□ Epilepsy □ Thyroid
□ Heart Problem □ Varicose Veins
□ Pace Maker □ Implants
□ Herpes □ HIV
□ Scars □ Moles
List any medications and vitamins that you take regularly:

Smoke? □ Yes □ No
Use Retin-A? □ Yes □ No
Ever use drug Accutane? □ Yes □ No
Wear contact lenses? □ Yes □ No
□ Cosmetics □ Pollen □ Animals
Have you ever had a reaction to any of the following?
□ Medicine □ Food □ Fragrance
□ Iodine □ AHAs □ Sunscreens
□ Other_____

Female Clients Only

Are you taking oral contraception?
□ Yes □ No
Are you pregnant or trying to become pregnant? □ Yes □ No

Male Clients Only

Do you ever experience irritation from shaving? □ Yes □ No
Do you experience ingrown hair? □ Yes □ No

OIL SECRETION

Do you experience an oily during the day? □ Yes □ No
Do you experience skin break-outs?
□ Yes □ No □ Occasionally

MOISTURE HYDRATION

How much plain water do you drink daily? _____

How much alcohol do you consume weekly?
□ None □ 1-3 □ 4 or more
Do you ever experience these conditions on your skin?

□ Flakiness □ Tightness □ Dryness
If you sunbathe, do you use sun block on your skin? □Yes SPF _____ □ No

CAPILLARY ACTION

Do you burn easily in moderate sunlight? □Yes □ No
Do you blush easily when nervous? □ Yes □ No
Do you have a tendency to redness? □ Yes □ No

How many cups of caffeine type beverages (coffee, tea, soda?) do you drink daily? □None □1-3 □ 4 or more

Do you take any stimulants or slimming tablets?
□ Yes □ No □ Occasionally

Have you ever experienced any claustrophobia? □ Yes □ No

Do you have any special skin problems pertaining to your face? □ Yes □ No

Specify: _____

Please list the brand of products you are currently using:
Cleanser: _____ Toner/Lotion: _____

Moisturize: _____ Scrub/Peel: _____

Mask: _____ Other: _____

Are you currently having or due for your menstrual cycle?
□ Yes □ No
Have you had any recent dental X-Rays?
□ Yes □ No
Have you started any new medication?
□ Yes □ No Specify: _____

I confirm to the best of my knowledge, that the answers I

Have given are correct and that I have not with held any

Information that may be relevant to my treatment.

Therefore, I do not hold the therapist or Zen Retreat Inc. liable.

Signature _____