



**Dr. Michael Richie**  
 Heather Breck, Clinical Esthetician  
 Jessica Kelm, Registered Nurse  
 1575 20th Street NW, Suite 101  
 Faribault, MN 55021  
 Phone: 507-209-6229

CLIENT REGISTRATION

CONTACT INFORMATION				
TITLE <input type="checkbox"/> MR. <input type="checkbox"/> MISS <input type="checkbox"/> MRS. <input type="checkbox"/> DR.		NAME (LAST NAME FIRST)		DATE OF FIRST VISIT
ADDRESS			CITY	STATE    ZIP CODE
DATE OF BIRTH	E-MAIL	HOME PHONE	CELL/PAGER	
HOW DID YOU HEAR ABOUT US?				

MEDICAL HISTORY (CHECK ALL THAT APPLY)			
<b>GENERAL</b>			
<input type="checkbox"/> LOW BLOOD PRESSURE	<input type="checkbox"/> SINUS PROBLEMS	<input type="checkbox"/> AREA OF INFLAMMATION: _____	
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SEIZURES/CONVULSIONS	<input type="checkbox"/> INFECTIOUS CONDITION: _____	
<input type="checkbox"/> CHEST PAINS	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ALLERGIES: _____	
<input type="checkbox"/> HEART ATTACK	<input type="checkbox"/> HORMONAL PROBLEMS	<input type="checkbox"/> SKIN CONDITION/RASH: _____	
<input type="checkbox"/> BRUISE EASILY	<input type="checkbox"/> SHORTNESS OF BREATH	<input type="checkbox"/> THYROID (OVER OR UNDER)	<input type="checkbox"/> OSTEOPOROSIS
<input type="checkbox"/> VARICOSE VEINS/PHLEBITIS	<input type="checkbox"/> ASTHMA OR BREATHING PROBLEMS	<input type="checkbox"/> JOINT DISORDER	<input type="checkbox"/> NUMBNESS/PARALYSIS
PLEASE LIST ANY OTHER MEDICAL CONDITION OR SYMPTOMS: _____			
DO YOU HAVE ANY IMPLANTS, PACEMAKERS, PINS IN BONES, ETC.?: _____			
PLEASE LIST ANY ORAL MEDICATIONS YOU CURRENTLY TAKE (INCLUDE HORMONES, BIRTH CONTROL PILLS, ANTIBIOTICS, TRANQUILIZERS, ANTI-DEPRESSANTS, DIURETICS, ETC.): _____			
ARE YOU CURRENTLY OR HAVE YOU EVER BEEN UNDER THE CARE OF A PHYSICIAN FOR ANY MEDICAL PROBLEMS? (IF YES, EXPLAIN): _____			
_____		NAME OF PHYSICIAN: _____	
LIST ANY HISTORY OF SURGICAL PROCEDURE, INCLUDING COSMETIC SURGERY & DATE: _____			
_____		NAME OF PHYSICIAN: _____	
CLIENT SIGNATURE: _____		DATE: _____	



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SKINCARE QUESTIONNAIRE

**CONTACT INFORMATION**

TITLE <input type="checkbox"/> MR. <input type="checkbox"/> MISS <input type="checkbox"/> MRS. <input type="checkbox"/> DR.	NAME (LAST NAME FIRST)	AGE	DATE
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**SKINCARE QUESTIONNAIRE**

ARE YOU CURRENTLY UNDER THE CARE OF A DERMATOLOGIST OR A PHYSICIAN FOR YOUR SKIN? (IF YES, EXPLAIN): \_\_\_\_\_

\_\_\_\_\_ NAME OF PHYSICIAN: \_\_\_\_\_

HAVE YOU EVER SEEN A DERMATOLOGIST OR OTHER PHYSICIAN FOR YOUR SKIN? (IF YES, EXPLAIN): \_\_\_\_\_

\_\_\_\_\_ NAME OF PHYSICIAN: \_\_\_\_\_

WHAT SKINCARE PRODUCTS DO YOU USE ON YOUR FACE? \_\_\_\_\_

HAVE YOU PREVIOUSLY HAD:

- CHEMICAL PEELS                      DATE: \_\_\_\_\_
- LASER RESURFACING                      DATE: \_\_\_\_\_
- DERMABRASION                              DATE: \_\_\_\_\_
- MICRODERMABRASION                      DATE: \_\_\_\_\_
- AGGRESSIVE EXFOLIATION TREATMENT IN THE LAST 2 WEEKS? (EXPLAIN): \_\_\_\_\_

ARE YOU USING OR HAVE EVER USED:

- RETIN A OR RENOVA                      DATE: \_\_\_\_\_
- RETINOL                                      DATE: \_\_\_\_\_
- HYDROQUINONE                              DATE: \_\_\_\_\_
- OTHER (INCLUDE TOPICAL ANTIBIOTIC, OTC ACNE REMEDIES, ETC.): \_\_\_\_\_
- ARE YOU TAKING ACCUTANE®?     YES    NO    IF YES, WHAT IS THE DOSAGE AND FREQUENCY?: \_\_\_\_\_
- HAVE YOU EVER TAKEN ACCUTANE®?     YES    NO    IF YES, LAST TAKEN ON?: \_\_\_\_\_

**HYPERSENSITIVITY AND SKIN FRAGILITY**

HAVE YOU EVER HAD A SKIN ALLERGY OR SENSITIVITY (RASH, IRRITATION, PEELING, SWELLING, HIVES, ETC.)? \_\_\_\_\_

COSMETICS?     YES    NO    FABRICS?     YES    NO    OTHER (LATEX, ETC.)?     YES    NO

DO YOU HAVE ANY KNOWN SYSTEMIC ALLERGIES TO ANYTHING? (IF YES, PLEASE LIST): \_\_\_\_\_

DO YOU "FLUSH" OR "APPEAR REDDENED" EASILY WHEN YOU EAT SPICY FOOD, DRINK ALCOHOL, GET ANGRY, GO IN THE SUN, ETC.?    YES     NO

**FREE RADICAL EXPOSURE**

DO YOU EXERCISE?  YES  NO HOW OFTEN?: \_\_\_\_\_

DO YOU SMOKE?  YES  NO HOW MUCH? \_\_\_\_\_

DO YOU CONSUME ALCOHOL?  YES  NO HOW MUCH? \_\_\_\_\_

DO YOU HAVE A HEALTHY DIET?  YES  NO LIST ANY DIETARY CONCERNS: \_\_\_\_\_

DO YOU FOLLOW A SPECIAL DIET?  YES  NO EXPLAIN: \_\_\_\_\_

DO YOU DRINK 8 GLASSES OF WATER/DAY?  YES  NO IF NOT, HOW MUCH? \_\_\_\_\_

DO YOU TAKE VITAMINS?  YES  NO TYPE OF VITAMINS: \_\_\_\_\_

ANTIOXIDANTS: \_\_\_\_\_ OTHERS: \_\_\_\_\_

**FOR WOMEN ONLY**

DO YOU HAVE REGULAR PERIODS?  YES  NO ARE YOU GOING THROUGH MENOPAUSE?  YES  NO

ARE YOU PREGNANT OR LACTATING?  YES  NO HAVE YOU EVER BEEN PREGNANT?  YES  NO

ARE YOU TRYING TO BECOME PREGNANT?  YES  NO

DURING PREGNANCY, DID YOU EVER EXPERIENCE HYPERPIGMENTATION OR A 'PREGNANCY MASK'?  YES  NO

**PIGMENTATION (FITZPATRICK SCALE)**

HOW DO YOU TAN?  BURN (I)  USUALLY BURN (II)  SOMETIMES BURN (III)

RARELY BURN (IV)  NEVER BURN - "BROWN" (V)  NEVER BURN - "BLACK" (VI)

PIGMENTATION:  HYPERPIGMENTATION  HYPOPIGMENTATION  BIRTHMARK

PREGNANCY MASK  OTHER: \_\_\_\_\_

WHAT IS YOUR NATIONALITY (HERITAGE)?: \_\_\_\_\_

**ACNE**

DO YOU HAVE ANY HISTORY OF ACNE OR PERIODIC BREAKOUTS?  YES  NO

PIMPLES  WHITE HEADS  BLACKHEADS  ENLARGED PORES

ACNE SCARS  CYSTS  FLAKINESS

DO YOU ONLY EXPERIENCE A BREAKOUT DURING YOUR MENSTRUAL CYCLE?  YES  NO

DO YOU ALWAYS HAVE A PIMPLE OR SOME TYPE OF BREAKOUT?  YES  NO

**FACIAL WRINKLES**

DO YOU HAVE:  DEEP WRINKLES  FINE LINES  CROWS FEET

HAVE YOU BEEN TREATED WITH:  BOTOX/TX DATE: \_\_\_\_\_  COLLAGEN/TX DATE: \_\_\_\_\_  RESTYLANE/TX DATE: \_\_\_\_\_

**SKIN TYPE**

- DOES YOUR SKIN EVER FLAKE OR FEEL TIGHT & DRY?     FREQUENTLY     OCCASIONALLY     VERY RARELY
- IS YOUR SKIN EVER SHINY A FEW HOURS AFTER CLEANING?     FREQUENTLY     OCCASIONALLY     VERY RARELY
- HOW OFTEN DO YOU EXPERIENCE BLACKHEADS OR BLEMISHES?     FREQUENTLY     OCCASIONALLY     VERY RARELY
- HOW NOTICEABLE ARE YOUR PORES?     VERY     T-ZONE     NOT VERY

**ABILITY TO HEAL**

- DOES YOUR SKIN APPEAR FRAGILE OR BURN EASILY?     YES     NO    IF YES, EXPLAIN: \_\_\_\_\_
- DO YOU HAVE ANY PROBLEMS HEALING FROM A CUT OR BURN?     YES     NO    IF YES, EXPLAIN: \_\_\_\_\_
- DO YOU EVER USE DIPILATORIES OR WAXES ON YOUR FACE?     YES     NO    IF YES, EXPLAIN: \_\_\_\_\_
- HAVE YOU EVER HAD A 'COLD SORE'?     YES     NO    IF YES, EXPLAIN: \_\_\_\_\_

**SKIN HISTORY & LIFESTYLE**

- DO YOU WORK INSIDE?     YES     NO    OCCUPATION: \_\_\_\_\_
- ARE YOUR HOBBIES DONE MOSTLY OUTSIDE?     YES     NO    HOBBIES: \_\_\_\_\_
- IN THE PAST (INCLUDING CHILDHOOD) DID YOU LIVE IN A SUNBELT?     YES     NO    WHERE DID YOU LIVE?: \_\_\_\_\_
- IN THE PAST HAVE YOU NEGLECTED TO USE SUNSCREEN?     YES     NO    IF YES, EXPLAIN: \_\_\_\_\_
- DO YOU EVER USE TANNING BEDS?    IF YES, WHEN?: \_\_\_\_\_
- DO YOU CURRENTLY WEAR A SUN PROTECTION PRODUCT ALL DAY, EVERYDAY?    YES     NO
- ARE YOU WILLING TO WEAR A SUN PROTECTION PRODUCT ALL DAY, EVERYDAY?    YES     NO
- HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD SKIN CANCER?    YES     NO
- IF YES, WHO?: \_\_\_\_\_ ANATOMICAL LOCATION: \_\_\_\_\_

**ENVIRONMENTAL POLLUTION**

- ARE YOU EXPOSED TO:     WORKPLACE POLLUTION     POOR VENTILATION     SECONDHAND SMOKE
- HOW DO YOU WANT TO CHANGE AND IMPROVE YOUR SKIN?: \_\_\_\_\_
- WHAT SPECIFIC AREAS DO YOU WANT TO TREAT?     NECK     FACE     CHEST     BACK     OTHER
- DO YOU WEAR CONTACT LENSES?     YES     NO

**SKIN CARE CONSENT:** I understand that although the products used for facial and body treatments at Crossroads Skin Care is of the highest quality, it is possible that I may have an adverse reaction to a product or treatment. I understand that the risk of an adverse reaction is extremely low, however, I accept the risk and consent to treatment by the therapists at Crossroads Skin Care.

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

THERAPIST SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_