CLIENT HISTORY PROFILE FORM

Contact Info:
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Address: 97-10th Street, Parkmore - Johannesburg
Website: www.pcasa.org.za

Name:	***Date:***
Address:	***City:***
Occupation/Employer:	***Tel (H):***
Gender: ***Female:*** ☐ ***Male:*** ☐	***Tel (W):***
Age:	***Mobile:***
Email Address:	***Doctor's Name:***
How did you hear of us?	***Dr's Contact No.:***

If you answer "Yes" to any of the questions below, please elaborate in the space given at the end of the sheet. Please give the number of the question next to your answer Please also state any conditions that we have not listed. These answers give your technician valuable information with regards to your application or healing time etc.

No.	Question	Yes / No	No.	Question	Yes / No
1.	Do you take any form of aspirin daily?	Yes No	28.	Are you diabetic? Type 1 or type 2? ____	Yes No
2.	Are you pregnant or breast feeding?	Yes No	29.	Do you use a sun bed?	Yes No
3.	Are you being treated for depression?	Yes No	30.	Do you spend lots of time in the sun tanning?	Yes No
4.	Have you recently had surgery ? *Specify*	Yes No	31.	Do you currently have any contagious ailments?	Yes No
5.	Have you consumed any alcohol in the last 24hrs?	Yes No	32.	Do you have any auto immune disorders or diseases?	Yes No
6.	Do you have a history of cold sores / fever blisters?	Yes No	33.	Are you sensitive to hand creams, soaps or body lotions?	Yes No
7.	Do suffer from an allergy to latex?	Yes No	34.	Do you have a history of strokes or heart attacks?	Yes No
8.	Are you sensitive to petroleum based products?	Yes No	35.	Do you have a history of cancer? *(any type)*	Yes No
9.	Have you had a laser/chemical peel within the last 6 months?	Yes No	36.	Do you react to anesthetic? *(i.e. for a dental procedure)*	Yes No
10.	Have you ever had botox injections?	Yes No	37.	Do you react to hair dyes?	Yes No
11.	Have you ever had permanent make-up before?	Yes No	38.	Have you had filler injections? *(i.e. on lips)*	Yes No
12.	Do you have any tattoos?	Yes No	39.	Do you develop *keloid* or *hypertrophy* scars?	Yes No
13.	Did you have any problem healing after your tattoo or permanent make-up?	Yes No	40.	Do you menstruate? *Next cycle date:* _____	Yes No
14.	Do you bruise easily?	Yes No	41.	Do you hyper pigment? *(dark spots)*	Yes No
15.	Are you currently having any radiation or chemotherapy treatment?	Yes No	42.	Do you hypo pigment? *(white spots/lack of pigment)*	Yes No
16.	Do you suffer from anemia?	Yes No	43.	Is your blood pressure: *Low__ Normal __ High __*	Yes No
17.	Have you ever been on acne treatment Accutane *(or similar)*?	Yes No	44.	Do you have any eye disease or disorder? *(i.e. Glaucoma)*	Yes No
18.	Do you or have you used exfoliating products such as Retin-A or glycolic?	Yes No	45.	Do you have arthritis?	Yes No
19.	Do you use prescription drugs?	Yes No	46.	Do you suffer from any sinus problems?	Yes No
20.	Do you heal slowly from small wounds?	Yes No	47.	Do you have any type of Hepatitis?	Yes No
21.	Do you wear contact lenses?	Yes No	48.	Are you sensitive or allergic to any metals? *(i.e. costume jewelry / nickel)*	Yes No
22.	Do you have an oily skin?	Yes No	49.	Do you scar easily from minor skin injuries?	Yes No
23.	Do you have any allergies to normal topical make-up?	Yes No	50.	Do you faint or become dizzy often?	Yes No
24.	Do you have a sensitive skin?	Yes No	51.	Do you suffer from any types of seizures?	Yes No
25.	Do you have any heart conditions? *Or* have a pacemaker?	Yes No	52.	Do you bleed excessively, even from a small wound?	Yes No
26.	Do you suffer from dry eyes?	Yes No	53.	Do you have any prosthetic s? *i.e. Limbs, breast implants etc*	Yes No
27.	Do you suffer from hay fever?	Yes No	54.	Do you smoke? **Smokers heal more slowly & affect any healing timelines and future appointment dates given.*	Yes No

Skin Analysis:

1. Skin type and condition:
2. Skin tugor *(plumpness/ collagen strength / elasticity)*:
3. Moisture content:
4. Skin thickness:
5. Texture:
6. Pore Size:
7. UV Sensitivity:
8. Pigmentation:
9. Skin Colour & Complexion:
10. Skin Imperfections:
11. Superfluous Hair (area, amt):
12. What skin products are you currently using?

Soap:	Cleanser:	Toner:	Moisturizer:
Masque:	Exfoliator:	Eye Gels:	Other:

General Lifestyle:

1. Do you smoke? Yes No
2. Do you exercise regularly? Yes No
3. Do you drink alcohol regularly? Yes No
4. How much water do you drink per day? *Specify*___________________________
5. Do you take any supplements/vitamins/diuretics/slimming tablets etc.? Yes No *Specify* ___________________________

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Client Signature: .... ***Date:*** ....

For Therapist Use:

Date	Treatment	Colour	Range	Price

Other:

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