

# NANCY K. BROWN (N.K.B.) AESTHETICS, INC.

preventive and corrective skin, body, foot and nail care

www.nancykbrown.com

## CLIENT HISTORY AND CONSULTATION FORM

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To be used during initial consultation with client and to be updated regularly: (only fill in applicable areas)

### PERSONAL INFORMATION:

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Sex (female/male): \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Daytime Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Evening Telephone: ( \_\_\_\_ ) \_\_\_\_\_ Other Telephone: ( \_\_\_\_ ) \_\_\_\_\_  
Parent/Guardian: (if under 18 yrs.) \_\_\_\_\_ Your Age: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Referring doctor: \_\_\_\_\_ Phone #: ( \_\_\_\_ ) \_\_\_\_\_  
Nationality: \_\_\_\_\_ Race: \_\_\_\_\_  
Have you ever seen a dermatologist? (Y/N): \_\_\_\_\_ How long: \_\_\_\_\_ Currently seeing dermatologist? (Y/N): \_\_\_\_\_  
Name of current dermatologist, if any: \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_

### PRESCRIBED MEDICATIONS:

Antibiotics (Y/N): \_\_\_\_ What kind? \_\_\_\_\_ Side effects? \_\_\_\_\_  
Accutane (Y/N): \_\_\_\_ When? \_\_\_\_\_ How long?: \_\_\_\_\_ Sulfur(Y/N): \_\_\_\_ Peeling(Y/N): \_\_\_\_\_  
Ever used Benzoyl Peroxide, Oxy 10, Prescription Benzoyl? \_\_\_\_\_ Retin A: \_\_\_\_ Cream: \_\_\_\_ Gel: \_\_\_\_\_  
Any allergic reaction to Benzoyl Peroxide? (such as swelling, severe itching, rash, fine bumps) \_\_\_\_\_  
Currently using Benzoyl Peroxide (Y/N): \_\_\_\_ Allergic to Aspirin or its derivatives (Y/N): \_\_\_\_  
Strength of product used: \_\_\_\_\_ Cortisone: \_\_\_\_ Cleocin-T: \_\_\_\_ E-mycin-T: \_\_\_\_\_  
Over the Counter Products: \_\_\_\_ Which products: \_\_\_\_\_  
Have you ever used "Bleach Cream" or Fade Cream?(Y/N): \_\_\_\_ Which?: \_\_\_\_\_  
Allergic reaction to bleach or fade cream? (such as swelling, severe itching, rash, fine bumps) \_\_\_\_\_  
Sensitivity to Aloe or Aloe Vera (Y/N): \_\_\_\_ Which product: \_\_\_\_\_  
Sensitivity to any other products, which? \_\_\_\_\_

### PRODUCTS CURRENTLY USED BY CLIENT: (important fill in completely)

Cleanser: \_\_\_\_\_ Toner: \_\_\_\_\_  
Exfoliator: \_\_\_\_\_ Hydrator: \_\_\_\_\_  
Moisturizer: \_\_\_\_\_ Sunscreen or Sunblock: \_\_\_\_\_  
Special Condition Products (e.g. Hyperpigmentation Gels etc.) \_\_\_\_\_  
Foundation: \_\_\_\_\_ Makeup: \_\_\_\_\_  
Makeup remover: \_\_\_\_\_ Hair Products: \_\_\_\_\_  
Hair Spray/Conditioning Spray: \_\_\_\_\_ Cover-up makeup: \_\_\_\_\_

### FACIAL SKIN TYPE: What does client consider his/her skin type to be? \_\_\_\_\_ Why? \_\_\_\_\_

Aesthetician analysis of client's skin \_\_\_\_\_  
Facial Skin Type: Oily: \_\_\_\_ Oily where? \_\_\_\_\_  
How many hours after cleansing does skin become oily again? \_\_\_\_\_  
Dry: \_\_\_\_ Dry where? \_\_\_\_\_  
Sensitive: \_\_\_\_ Sensitive where? \_\_\_\_\_  
Combination: \_\_\_\_ Combination of which types: \_\_\_\_\_  
Acne (Y/N): \_\_\_\_ Age acne started: \_\_\_\_ History of acne in family (Y/N): \_\_\_\_ Which relatives? \_\_\_\_\_  
Areas affected by acne: Face: \_\_\_\_ Chest: \_\_\_\_ Back: \_\_\_\_ Upper arms: \_\_\_\_ Other areas: \_\_\_\_\_  
Blackheads: \_\_\_\_ Whiteheads: \_\_\_\_ Pustules: \_\_\_\_ Cysts: \_\_\_\_ Scarring: \_\_\_\_\_  
Skin discoloration (Y/N): \_\_\_\_ Dark spots: \_\_\_\_ Melasma (dark patches): \_\_\_\_ Milia: \_\_\_\_ Keloid-Former: (Y/N) \_\_\_\_\_  
Do dark spots worsen in summer(Y/N): \_\_\_\_ Average amount of sun exposure: winter: \_\_\_\_ hrs. summer: \_\_\_\_ hrs.  
Flesh Moles: \_\_\_\_ Other: \_\_\_\_ Explain condition or problem in detail: \_\_\_\_\_

### SHAVING HABITS AND PROBLEMS: (men and women)

Razor bumps (Y/N): \_\_\_\_ Irritation (where, when): \_\_\_\_\_ Itching: \_\_\_\_\_  
Razor type: Single blade: \_\_\_\_ Double blade: \_\_\_\_ Brand name: \_\_\_\_\_ Electric: \_\_\_\_ Make: \_\_\_\_\_  
Direction of Stroke: Upward: \_\_\_\_ Downward: \_\_\_\_ Both: \_\_\_\_ Frequency of shaving (e.g. daily): \_\_\_\_\_  
How many times is blade used before disposal? \_\_\_\_\_ How often electric razor cleaned?: \_\_\_\_\_  
Shaving products used: \_\_\_\_\_ Aftershave used? \_\_\_\_\_

**HEALTH HISTORY:** page 2

Illness: \_\_\_\_\_ Past 2 years: \_\_\_\_\_  
 Chronic Problems: \_\_\_\_\_  
 Medications: \_\_\_\_\_ Side Effects: \_\_\_\_\_  
 Organ Transplant: \_\_\_\_\_ Medication: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Thyroid Condition(Y/N): \_\_\_ Medication: \_\_\_\_\_ Anemic: \_\_\_\_\_ Other: \_\_\_\_\_  
 Other health problems: \_\_\_\_\_  
 Allergies, which, when?: \_\_\_\_\_

**WOMEN ONLY:**

Pregnant (Y/N): \_\_\_ PMS (Y/N): \_\_\_ Premenstrual breakouts (Y/N): \_\_\_ Regular Periods (Y/N): \_\_\_ Time: \_\_\_\_\_  
 Food Cravings (Y/N): \_\_\_ Foods Craved: \_\_\_\_\_  
 Birth Control (Y/N): \_\_\_ Pill (Y/N): \_\_\_ Brand name: \_\_\_\_\_ Other: \_\_\_\_\_  
 Currently on Pill (Y/N): \_\_\_ How long: \_\_\_\_\_ yrs. \_\_\_\_\_ months: \_\_\_\_\_ same brand as listed above(Y/N): \_\_\_

**CLIENT LIFE STYLE:**

Type of Work: \_\_\_\_\_  
 Stress Level: High: \_\_\_ Med.: \_\_\_ Low: \_\_\_ Night shift: \_\_\_ Hours worked: \_\_\_\_\_ Subject to noise at work(Y/N): \_\_\_  
 Do you work with chemicals (oils, tar etc.): \_\_\_\_\_  
 Do you work with essential oils (aromatherapy): \_\_\_\_\_  
 Do you use Tea Tree Oil (Y/N): \_\_\_ What other disinfectants?: \_\_\_\_\_  
 Amount of daily sun exposure: \_\_\_\_\_ hrs. On weekends: \_\_\_\_\_ hrs. Hours sleep per night/day: \_\_\_\_\_  
 Do your dark spots worsen during summer (Y/N): \_\_\_ Salty snacks: \_\_\_\_\_ Peanut products: \_\_\_\_\_  
 Do you salt foods (Y/N): \_\_\_ Fast Foods (Y/N): \_\_\_ Kelp/Seaweed: \_\_\_ Ethnic Foods: \_\_\_\_\_  
 Milk Products: \_\_\_\_\_ Vitamins - list all: \_\_\_\_\_  
 Do you smoke (Y/N): \_\_\_ How often: \_\_\_ Do you drink (Y/N): \_\_\_ How often: \_\_\_\_\_  
 Do you exercise (Y/N): \_\_\_ How often: \_\_\_\_\_ Steroid use (Y/N): \_\_\_ Brand: \_\_\_\_\_  
 Detergent Brand: \_\_\_\_\_ Brand of fabric softener: \_\_\_\_\_  
 Do you use phone frequently (Y/N): \_\_\_ Which side? \_\_\_\_\_  
 Do you swim or use hot tube (Y/N): \_\_\_ How often? \_\_\_\_\_ Does client shower afterward (Y/N): \_\_\_  
 Do you sunbathe or use sun tanning beds (Y/N): \_\_\_ How often: \_\_\_\_\_  
 What results do you hope to obtain? \_\_\_\_\_  
 Anything else we should know? \_\_\_\_\_  
**If appropriate take a BEFORE PICTURE for client record for future reference and comparison!**  
 Picture taken (Y/N): \_\_\_\_\_

**PAYMENT:**

Who is responsible for paying? \_\_\_\_\_  
 Method of payment: Check: \_\_\_\_\_ Cash: \_\_\_\_\_ Credit Card (which one): \_\_\_\_\_  
 Credit Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_ Name (on card): \_\_\_\_\_  
 Is money a problem for you now (Y/N)? \_\_\_ Reason: \_\_\_\_\_

Your consultation today is \$ \_\_\_\_\_ Since our programs usually run between \$ \_\_\_\_\_ and \$ \_\_\_\_\_ to start, what can you (the client) afford as an initial outlay if you would like to begin your skin care therapy program today: \$ \_\_\_\_\_ .  
 Our program includes a *HomeCare* regimen specifically designed for your skin care needs and professional clinical treatments. These may include vitamin and homeopathic supplementation, special make-up. Consistent weekly or biweekly follow-up visits are included in your complete program. (Follow up visits for "chronic no-show" returning clients are \$ 60 days or more after the date of the initial consultation when weekly or biweekly appointments are not kept).  
**I, the client, certify that the above information is true and correct!**

Client signature: \_\_\_\_\_ Date(DD/MM/YY): \_\_\_\_\_



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