



## CLIENT PROFILE

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

THIS OFFICE DOES NOT RELEASE CLIENT INFORMATION TO THIRD PARTIES. IW SENDS EMAIL OR POST MAIL FOR SEASONAL OCCASIONS

Are you pregnant or lactating? Yes \_\_\_ No \_\_\_

(Only the Oxygenating Trio Detox Gel deep pore treatment is appropriate. Please consult with your Obstetrician.)

Do you wear contact lenses? Yes \_\_\_ No \_\_\_

(Remove contacts if eyes are sensitive or if having microdermabrasion.)

Do you have permanent makeup? Yes \_\_\_ No \_\_\_ (If so, to what areas of the face?) \_\_\_\_\_

Do you currently use or receive facial depilatories or waxing? Yes \_\_\_ No \_\_\_ (Discontinue use five days pre and post-treatment.)

Do you currently have a sunburn/windburn/red face? Yes \_\_\_ No \_\_\_ Why? \_\_\_\_\_

Are you in the habit of going to tanning booths? Yes \_\_\_ No \_\_\_

(If within past 14 days, decline treatment; we recommend this practice is discontinued altogether.)

Are you applying any topical medications at this time? Yes \_\_\_ No \_\_\_ Which one(s)? \_\_\_\_\_

(High percentages of certain ingredients may increase sensitivity)

Are you currently using any topical Retnoid prescriptions (Trentinoin/Retin-A/Renova®/Differin®/Tazorac®/Avage®/EpiDuo™/Ziana®) Yes \_\_\_ No \_\_\_ What strength? \_\_\_\_\_ For how long? \_\_\_\_\_

(Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)

Are you currently using Acutane®? Yes \_\_\_ No \_\_\_ For how long? \_\_\_\_\_

(It's okay to apply ONE layer of Ultra Peel® I, Sensi® Peel, Ultra Peel® II, Esthetique Peel or Oxy Trio to skin that has been treated with Accutane®.) Those who are currently taking Accutane® should be directed to their dispensing physician.

Have you had a chemical peel or any type of procedure with a medical device? Yes \_\_\_ No \_\_\_ Within the last 14 days? Yes \_\_\_ No \_\_\_

What type?

Do you have regular collagen, Botox® or other dermal filler injections? Yes \_\_\_ No \_\_\_

(Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)

Have you recently had facial surgery? Yes \_\_\_ No \_\_\_ Describe: \_\_\_\_\_ How long ago? \_\_\_\_\_

Have you recently had laser resurfacing? Yes \_\_\_ No \_\_\_ When? \_\_\_\_\_ What type? \_\_\_\_\_



What type of work do you do? \_\_\_\_\_ Regular airline travel? Yes \_\_\_ No \_\_\_ How often? \_\_\_\_\_

Do you smoke or use tobacco? Yes \_\_\_ No \_\_\_

Do you develop cold sores/fever blisters? Yes \_\_\_ No \_\_\_ Last breakout? \_\_\_\_\_

Are you allergic/sensitive to? (Check all that apply) milk \_\_\_ apples \_\_\_ citrus \_\_\_ grapes \_\_\_ aloe vera \_\_\_ aspirin \_\_\_ perfumes \_\_\_ latex \_\_\_ hydroquinone \_\_\_ mushrooms \_\_\_ if any other allergies, what? \_\_\_\_\_

Are you sensitive to alcohol-based products? Yes \_\_\_ No \_\_\_

Have you ever used any other products that caused a bad reaction? Yes \_\_\_ No \_\_\_ Describe \_\_\_\_\_

Are you taking any medication at this time? (i.e. Antibiotics may increase sensitivity) \_\_\_\_\_

What is your hereditary background? \_\_\_\_\_

Natural eye color: Blue \_\_\_ Green \_\_\_ Hazel \_\_\_ Gray \_\_\_ Lt. Brown \_\_\_ Med. Brown \_\_\_ Dk. Brown \_\_\_

Natural hair color: Blond \_\_\_ Red \_\_\_ Lt. Brown \_\_\_ Med. Brown \_\_\_ Dk. Brown \_\_\_ Black \_\_\_ Gray/Silver \_\_\_ White \_\_\_

Skin tone: Pale/White \_\_\_ Light \_\_\_ Medium \_\_\_ Reddish \_\_\_ Freckled \_\_\_ Sallow \_\_\_ Lt. Olive \_\_\_ Med. Olive \_\_\_ Dark Olive \_\_\_ Lt. Brown \_\_\_ Med. Brown \_\_\_ Dk. Brown \_\_\_ Soft Black \_\_\_ Black \_\_\_

Do you consider your skin: Sensitive \_\_\_ Resilient \_\_\_ Unsure \_\_\_

Describe your skin (check all that apply): Normal \_\_\_ Dry \_\_\_ T-Zone/Combination \_\_\_ Thick \_\_\_ Thin \_\_\_ Saggy \_\_\_ Firm \_\_\_ Oily \_\_\_ Acne \_\_\_ Comedones/Blackheads \_\_\_ Milia \_\_\_ Cysts \_\_\_ Breakouts \_\_\_ Acne-Scarred \_\_\_ Large Pores \_\_\_ Small Pores \_\_\_ Flord \_\_\_ Rosacea \_\_\_ Eczema \_\_\_ Freckled \_\_\_ Sun-damaged \_\_\_ Melasma \_\_\_ Hyperpigmentation \_\_\_ Perfume-stained \_\_\_ Hypopigmentation \_\_\_ Uneven/blotchy \_\_\_ mature \_\_\_ Wrinkled \_\_\_ Patchy dryness \_\_\_ Sallow \_\_\_ Psoriasis \_\_\_ Dehydrated/ lacking moisture \_\_\_ Asphyxiated \_\_\_ Telangiectasia/broken surface capillaries \_\_\_

## **DISCLOSURES:**

I understand that if medical examination and diagnosis is needed for my physical or mental condition, I should see a medical specialist. I agree to keep the IW practitioners up to date during my session regarding my comfort. I also agree to update any changes in my IW general and medical profile. I hereby authorize IW practitioners to administer treatment. **CLIENT INITIALS:** \_\_\_\_\_

I acknowledge that any appointment cancelled without twenty-four hours notice will be charged to me. **CLIENT INITIALS:** \_\_\_\_\_

IW NOTES: