ROCCOCO PROFESSIONAL

SKIN CONSULTATION FORM

Please fill out this form on your first appointment. Your answers will help us to meet your needs that are suited to you.

CLIENT INFORMATION

Name

DOB

Address

City/Suburb

State

Postcode/Zip

Mobile Phone Number

Home

Work

Email

How did you hear about us? ○ Friend / Relative ○ Internet Search ○ Social Media

Please specify if other

I would prefer appointment reminders via ○ Email ○ SMS ○ Phone Call

Emergency Contact Details

Name

Contact Number

SKIN CONCERNS

○ Age spots ○ Sensitive skin ○ Oily skin ○ Flaky skin ○ Dry skin
○ Cysts ○ Whiteheads ○ Dehydrated skin ○ Lines / Wrinkles ○ Blackheads
○ Broken capillaries ○ Pimples / Pustules ○ Pigmentation / Melasma

Please specify if other

Does your skin breakout? ○ Never ○ Rarely ○ Frequently ○ Always

Have you ever been diagnosed with rosacea? ○ Yes ○ No

If so, do you know which type?

What is your main reason for visiting today?

CURRENT ROUTINE

Please list the name of any of the products you are currently using

Cleanser	Foundation
Toner / Essence	Concealer
Serums	Setting Powder
Moisturiser	Blush / Bronzer
Exfoliant	Setting Spray
Mask	Shampoo
Eye Cream	Conditioner
SPF	Leave in hair products
Primer	Other specialty products

Further Details

LIFESTYLE

Please note all answers are kept confidential.

Do you smoke tobacco/marijuana/vape? ○ Yes ○ No

Do you use tanning booths or artificially tan? ○ Yes ○ No

Do you have difficulty sleeping? ○ Yes ○ No

Do you wear sunscreen daily? ○ Yes ○ No

How many times per week do you exercise?

Please rate your current stress levels ○ Low ○ Moderate ○ High ○ Very High

Please rate your weekly alcohol intake ○ Low ○ Moderate ○ High ○ Very High

Please rate your daily water intake ○ Low ○ Moderate ○ High ○ Very High

How many hours do you spend outdoors per week, on average?
(Including gardening, exercise, leisure, sports, work, etc.)

○ 1 – 3 ○ 4 – 6 ○ 7 – 9 ○ 10+

Are you aware if you have any gynaecological disorders?

Are you aware if you have any hormonal imbalances?

Are you pregnant or trying to become pregnant?

Do you ever suffer from any of the following?

○ Bloating ○ Indigestion ○ Constipation ○ Diarrhoea ○ Gas

Do you regularly eat any of the following?

○ Dairy products ○ Seaweed ○ Sushi ○ Kelp ○ Pasta
○ White bread ○ Dining out ○ Fast food / Takeaway ○ Kombucha ○ Dates
○ Cacao / Cocoa

Further Details

TREATMENT HISTORY Have you ever received any of the following?

Chemical Peel Type of treatment

Time since last treatment Frequency of treatment

How long have you been receiving the treatment?

Laser or IPL Treatments Type of treatment

Time since last treatment Frequency of treatment

How long have you been receiving the treatment?

Microdermabrasion or Hydradermabrasion Type of treatment

Time since last treatment Frequency of treatment

How long have you been receiving the treatment?

Micro / Skin Needling or Dermaplanning Type of treatment

Time since last treatment Frequency of treatment

How long have you been receiving the treatment?

Recent Surgery Type of surgery

Date of surgery General or local anesthetic

Have you suffered any side effects during recovery?

Dermal Fillers or Anti-wrinkle Injections Type of treatment

Time since last treatment Frequency of treatment

How long have you been receiving the treatment?

Skin Cancer Removal / Treatment Type of treatment

Time since last treatment Frequency of treatment

How long have you been receiving the treatment?

Please list any other current treatments you are receiving (i.e. – facial treatments, hair removal / waxing, etc)

MEDICAL INFORMATION

Are you under a dermatologist or specialist's care ○ Yes ○ No

If yes, please list the treating specialist's name

Condition being treated / monitored

Allergies

Latex ○ Yes ○ No Sulphur: ○ Yes ○ No

Skin Care allergies / reactions ○ Yes ○ No

If yes, please list & specify

Please list any other known allergies you have

Do you ever suffer from any of the following

○ Asthma ○ Cancer ○ Depression ○ Psoriasis ○ Diabetes
○ Epilepsy ○ Hay Fever ○ Endometriosis ○ PCOS ○ IBS
○ Sinusitis ○ Heart Condition ○ Migraines ○ Cold Sores ○ Autoimmune Disorder
○ Eczema/Dermatitis ○ High / Low Blood Pressure ○ Contagious Disease / Infection

Have you ever or are you taking any of the following

○ Antibiotics for acne* ○ Birth Control* ○ Antiseizure Medication ○ Retin A**
○ Thyroid Medication ○ Danazol / Azol ○ Addiction Medication ○ Oral Tretinoin**
○ Antihistamines ○ Differin ○ Fertility Medication ○ Oral Steroids*
○ Recreational Drugs** ○ HR Therapy ○ Antidepressant / Anxiety Medication

How long ago

*How long were you on this medication

**Time since last use

Please list any other current medications & those ceased within the last 12 months

How long have you been on this medication

Please list all current herbs/vitamins/supplements you take

CLIENT TREATMENT RECORD

FOR PROFESSIONAL USE ONLY

Client Initial

FILE

Name

Date & Time

DD / MM / YY

HH : MM

Products Used in Treatment

Homecare Recommended

Problems

Effect

Treatment Plan

Notes

CONSENT FORM

I certify that the preceding medical, personal, and skin history statements are true and correct. I have disclosed any medical conditions that I have and / or medications I am taking (including topical, oral, and herbal or supplements). I am aware that it is my responsibility to inform the technician, aesthetician, therapist, doctor, or nurse of my current medical or health conditions and to update this history if it changes. A current medical history is essential for the caregiver to execute appropriate treatment procedures and in not doing so, expected results may be affected.

Name

Date Signature

If the patient is under the age of 18, the parent or guardian is also to give consent.

I, certify that I am the parent or legal guardian

of and verify that all information as stated above is true and correct. I give my permission for the discussed treatment/s to proceed and will notify the clinic of any changes to this form or consent.

Date Signature

*Photographic consent for minors must also be obtained

CLINICIAN ONLY SECTION

Photographic Consent given: ○ Yes ○ No

Initial photograph taken (1st visit): ○ Yes ○ No

Fitzpatrick Skin Type: ○ I ○ II ○ III ○ IV ○ V ○ VI

Notes