

URBAN SKIN SOLUTIONS

| | | | |
|---------------------------------|----------------|-------------------|------------------------|
| Last Name (Please Print): _____ | | First Name: _____ | |
| Today's Date: _____ | Program: _____ | No Program? _____ | Known Allergies? _____ |

CONSULTATION INTAKE FORM

Please answer all questions to the best of your ability. **PLEASE PRINT CLEARLY** and fill out this form completely before your consultation. **PLEASE FILL OUT COMPLETELY AND RETURN.**

Client name: _____ Date of birth: _____ Age: _____

Street address: _____ Apt./suite: _____

City: _____ State: _____ Zip code: _____

Home #: (____) _____ Work #: (____) _____ Cell: (____) _____

Parent/guardian: (If under 18 yrs.) _____ Email: _____

Referred by: _____

National origin: _____ Race: _____ Skin-tone: _____ Age your skin/scalp problem started: _____

Affected areas - Face: _____ Chest: _____ Back: _____ Upper Arms: _____ Other: _____

Acne in family /parents: _____ Siblings: _____ Other relatives: _____

PRESCRIBED MEDICATIONS: (Past and Present)

Antibiotics? Which one? _____ Side effects? _____ Still using? _____

Accutane? When? _____ Number/cycles? _____ List side effects: _____

Sulfur? Salicylic acid? Retinoids? Cream? Gel? Cortisone? Cleocin-T?

Over-the-counter product names: _____ Did you peel? _____

If yes, which product(s): _____ Strength: _____ Used Benzoyl Peroxide (BPO)? _____

Allergic reaction to BPO with swelling, severe itching, rash, fine bumps, swollen eyes: _____

Currently using BPO? On affected area Just on spots Allergy/stinging with aloe vera?

Have you ever used a "bleach cream" or "fade cream": _____ Brand names: _____

Allergic reaction to "bleach" or "fade" cream, with swelling, extreme itching, fine bumps: _____

| | | |
|---------------------------------------|---------------------------------------|--------------------|
| Do you consider your skin sensitive? | Do you get tight/dry after cleansing? | Explain in detail: |
| What products make you sting or itch? | | |

Do you experience itching? _____ How often? ___ Where? _____ Do you know why? _____

PRODUCTS YOU NOW USE (Fill in completely, using the Brand Names)

Cleanser: _____ Moisturizer: _____ Sunscreen brand: _____

Make-up: _____ Blusher? _____ Powder: _____ Cover-up: _____

Hair products: _____ Hair spray/conditioner spray:(Y/N) _____

Make-up: _____ Blusher? _____ Powder: _____ Cover-up: _____

Oil sheen/braid spray? ___ Want to wear cover-up? _____ Loose powder? _____ Pressed powder? _____

FACIAL SKIN TYPE

Oily/Dry: _____ Sensitive: _____ Combination: _____ Sun-damaged: _____ Scaling? _____ Where? ___ Redness? _____

How many hours after cleansing do you become oily? _____ Blackheads: _____ Whiteheads: _____

Cysts: _____ Pustules: _____ Milia around eyes: _____ Dark spots: _____ Melasma/dark patches? _____

Keloid-former: _____ Flesh moles: _____ Other: _____

Explain your skin or scalp problem in detail: _____

How often do you shampoo? _____ What happens if you don't? _____ Itching on scalp? _____

Hair loss at hairline? _____ Loss elsewhere? _____ Unexplained baldness? _____ Pimples on scalp? _____

Build-up of dead skin cells or excessive scaling? _____ Where? _____

Flaking/sensitivity in brows, on hairline, between brows, inner cheeks, sides of nose? _____

SHAVING PROBLEMS

| | | |
|--|------------------------|--------------------------------|
| Razor bumps? | Where? _____ | Irritation: _____ |
| Shadowing? | Itching: _____ | Dark Spots? _____ Where? _____ |
| Razor: Single edge? | Brand: _____ | Multi-blade? _____ |
| | Electric/Rotary? _____ | Make _____ |
| Stroke: Upward _____ | Downward _____ | Both _____ |
| | How often? _____ | Shaving powder? _____ |
| How many times do you use a blade? _____ times | Side effects? _____ | Shaving products: _____ |

| | | |
|-----------------------|-------------------------------------|---------------------------------|
| Do you wish to shave? | Neck/Scalp bumps (Acne Keloiditis)? | Preferred shaving method: _____ |
|-----------------------|-------------------------------------|---------------------------------|

HEALTH HISTORY

Illnesses in the past five years (describe): _____

HIV-Positive? Chronic problems: _____

Medications: _____ Effects: _____

Anemic? Herpes? Diabetic meds? What kind? _____ Diuretics?

Other health problems: _____ Ibuprophen? How often? _____

WOMEN ONLY

Pregnant now? PMS? Premenstrual breakouts? Regular periods?

Menstrual bloat? Pain? Salty food cravings? PMS Symptoms?

Birth control pill? Currently on the pill? How long? _____ Brand name: _____

Same brand? Depo Provera shot? When? _____ Side effects? _____

YOUR LIFESTYLE

Type of work: (describe): _____

Night shift? Graveyard shift? How long? _____ Number of hours worked? _____

Student? School: _____ Major? _____

Stress level: High Medium Low Subject to constant noise on the job?

Do you work around chemicals, tar, oil etc.? Describe: _____

Amount of daily sun exposure: _____ hrs. Weekends: _____ hrs. Sunscreen brand: _____ SPF: _____

Hours of sleep per night/day: _____ hrs. Broken sleep? Dark spots worse in the summer?

Water intake: _____/glasses per day Tea/coffee: _____/glasses per day Alcohol: _____/glasses per day

Salty snacks? Peanut products? Cheese? Do you salt your foods?

Do you eat: Fast foods? Kelp/seaweed? Ethnic foods? Seasoned salt?

Milk products: _____ Vitamins: List all: _____

Smoke marijuana? How often? _____ Other drugs? How often? _____

Smoke cigarettes? How much/day? _____ Do you exercise strenuously?

Steroid use? Workout clothing: Cotton? Spandex? Other? _____

Do you shower afterwards? Swim or use a hot tub often? Shower afterward?

Soap brand: _____ Detergent brand: _____ Fabric softener brand: _____ How many used/load? _____

On the phone a lot? _____ Which side? _____ Exactly what results do you hope to obtain? _____

Anything else we should know about? _____

Anything else we should know about? _____

PAYMENT (Fill Out Completely)

Who is responsible for paying? _____ Start today? _____ If not, when? _____

Payment method: Check Cash Debit Credit Card Which one? _____

I certify that all of above is true to the best of my knowledge. I am over 18 years of age.

Signature: _____ **Date:** _____

If under 18, parent or legal guardian's name: _____

Signature: _____ **Date:** _____

Skin Therapy Agreement

To avoid misunderstanding, please review carefully, then initial each line and sign the back.

The consultation fee is \$35. If you don't begin your program the same day, you have two weeks to begin the program to have this fee included in the price. No exceptions. All treatments included in Clinic Programs **MUST** be used **within 90 days** of starting your program. Series-of-Six treatments **MUST** be used within **six months** of purchase. No exceptions. **We have a strict 24-hour cancellation and no-show policy for weekday appointments scheduled on weekdays and a 48-hour policy for Saturday appointments.** Missed or canceled treatments included in Clinic Programs or Series of Six without proper notice will be forfeited.

In the event of a true skin allergy, problem product(s) only will be exchanged within first seven days with prior authorization. No exceptions. No refunds or product returns. Product refills are NOT included in programs. Refills are charged at individual prices, and no appointment is needed to pick-up refills. Customized Mailorder Programs are available for our out-of-town and relocated clients. Periodic follow-up visits are included in Complete Programs by appointment and must be scheduled at least every 30 days. If six months elapse after your last follow-up visit or clinic treatment, you "start over" with the complete consultation process. New intake and skin therapy forms must filled out yearly.

_____ I have read and understand my homecare and agree to follow directions. I understand my schedule for adapting my skin to new active products and acknowledge that (a) exceeding time limits or (b) applying too thick or too often can cause tightness, redness, stinging, flaking, itching and temporary darkening.

_____ I understand that dark spots don't always fade evenly, or at the same rate. Temporary blotchiness, with lighter normal skin tone "peeking" through, is normal. I understand it takes time for dark spots to fade and to achieve an even skin tone.

_____ I agree not to use other skin care products, cosmetics, make-up or hair products without reviewing them with the clinic.

_____ During the next few weeks, I may or may not experience some dryness, tingling, mild stinging, redness, itching, flaking, tightness, temporary darkening, blotchiness and mild peeling. I understand mild symptoms are temporary and will subside as my skin adapts to active products.

_____ When I apply my AHA (glycolic or lactic acid), BHA (salicylic acid), BPO (benzoyl peroxide), sulfur, skin brighteners and vitamin A products (retinoids, retinol), I will avoid the eye area, smile lines, corners of mouth and lips. I will use caution near the mouth, on the neck and on dry, sensitive or irritated areas.

_____ The earth's depleting ozone, the environment, sun exposure, my medical profile and many medications can make my skin "photo-sensitive". I agree to wear the sunscreen provided by the center exactly as directed on all exposed skin on a daily basis when sun-exposed for any length of time. I will reapply often, avoid sun whenever possible, and wear 100% UV protective sunglasses. I will not skip sunscreen on cloudy or overcast days.

_____ In the event of a poison ivy-type rash, accompanied by burning, redness, swelling and fine bumps, I will discontinue use and contact the center immediately.

_____ I understand benzoyl peroxide (BPO) may bleach hair and fabrics, and that all products should be kept out of the reach of children and others. I understand that I must wash my hands thoroughly after applying all therapeutic products. I understand that BPO and sulfur may temporarily tarnish my jewelry.

_____ I understand I may have or develop a sensitivity or allergy to chemical sunscreens, fragrances, sulfur, BPO, cosmetic ingredients or hydroquinone, and that in these cases, the problem product(s) only will be exchanged for an alternate product(s) within 10 days of purchase only. No exceptions.

_____ I agree to be consistent with product use, sunscreen use, follow-up visits and treatments. I understand that inconsistency may lead to new breakouts, flare-ups and discoloration. We are treating "controllable" skin disorders, with no permanent cure. Pitted scarring and rough texture can be improved, but will not disappear.

_____ I understand that lifestyle, stress, sun, friction, cosmetics, low water intake, salt, dairy intake, infrequent shampooing, unauthorized hair products, scented detergents, fabric softeners, toothpaste, picking, pregnancy, medical conditions and hormonal changes, weight gain, lack of sleep, night shift work, home care non-compliance, and/or skipping treatments will play a key role in the success or failure of my program.

_____ I will notify the center of changes to my lifestyle medical history, medications, address and telephone numbers.

_____ I understand that genetics (skin conditions that run in families), stress, lifestyle issues, hormonal imbalances, diet, medical conditions, obesity, prescription medications and shaving/haircut habits, may make some cases very difficult to treat. Urban Skin Solutions staff members can give no promises, time limits or guarantees. I understand there is no "Money Back Guarantee" on programs, products or treatments. We can't "go home with you" to monitor your program, product usage or lifestyle.

_____ I agree to keep my appointments and abide by Urban Skin Solutions' "Cancellation and No-Show Policy".

_____ I understand infants and small children cannot accompany me to my appointments or be in the treatment room. I agree to find childcare for scheduled treatments, facials, follow-up appointments and make-up blending, unless arrangements are made in advance.

_____ I will avoid excess sun, skip active products the night before if dry or sensitive, and not shave, scrub or workout for 24 hours before my treatments. I will avoid shaving, working out, direct sun, active products and scrubs for a full 24 hours after my treatments.

_____ I will not get relaxers, permanent haircolor or other chemical services, use shaving powder or depilatory, get electrolysis, laser treatments, waxing or chemical skin services, or prolonged sun for four days before and four days after my treatment at Urban Skin Solutions. I will not get aromatherapy, photo facials, microdermabrasion, laser (other than hair removal), and peels at other clinics, use a tanning bed or expose my skin to unnecessary sun.

_____ I understand that if I am exposed to excessive sun, using depilatories, Retinolic Serum, Green Cream®, Depigmenting Serum, Obagi®, Retin A®, Renova®, Differin®, other retinoids (tretinoin, retinol, retinoic acid, vitamin A products), I may not get waxed at the center or elsewhere in those areas of the skin. If I am taking Accutane® or micellized vitamin A, I may not get waxed at all. I also understand I must avoid skin peels from other clinics and will let the center know about topical products I use, surgeries and services I get, and all over-the-counter or prescription medications I take.

_____ I understand that eye creams, moisturizers and lip balms MUST NOT BE WORN around the eyes, the mouth, on the lips or on the neck while using benzoyl peroxide (BPO) because BPO can aggressively migrate right through these products onto the eye area, lips and neck. Swelling, dryness, tightness and temporary darkening may result.

_____ I understand that BPO and vitamin A products must not be worn in direct sunlight, or if I expect to perspire by exercising, hard labor, sleeping in a hot or overheated room, etc.

_____ I understand that I may experience a minor flare-up of acne during the early weeks of treatment. Tiny acne lesions may have already formed deep in my pores and will come to the surface. This is normal and temporary. Visible acne can take 60-90 days to clear. I understand that prior to my next two or three cycles, I may experience the usual breakouts.

_____ I agree to apply overnight medications as directed at least 30 minutes before bedtime, avoid the entire eye area, and to use caution on the neck and around the mouth. I will use a clean white pillowcase (laundered in unscented detergent) when wearing BPO. I will use products exactly as directed, and not "dot" skin lighteners or other active products onto dark spots, razor bumps or acne lesions.

_____ I understand that nutritional supplements (especially vitamin A), vitamin A creams, serums or gels, retinoids of any kind, and hydroquinone (HQ) must not be used by pregnant or lactating women.

_____ I understand that only partial use of recommended regimen and failure to make permanent lifestyle changes will provide less-than-satisfactory results.

_____ I request that Urban Skin Solutions, Inc. attempt to improve my skin and/or scalp problems. I understand that treatment usually consists of topical corrective creams, gels, sunscreens and masks, extraction of acne lesions and ingrown hairs, clinical exfoliation procedures and permanent lifestyle changes.

_____ I understand conditions including acne, razor bumps, eczema and inflamed scalp conditions can cause temporary and permanent scarring and/or skin discoloration. I understand that residual scarring and discoloration after your skin has cleared is not caused by the products or treatments, but by the condition itself, the length of time the condition was active, genetics, sun exposure, sun damage, picking, over-scrubbing, scratching and many other factors, including health and lifestyle.

_____ I consent to my treatment program. I have read and fully understand the above statements. I have been given a copy of this agreement for my reference. All of my questions have been answered to my satisfaction.

Name (Print Clearly): _____ **Address:** _____

Signature X: _____ **Phone:** _____ **Date:** _____

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