NEW LOOK LASER
Of Arlington Heights

Client Survey

Date: _____

First Name: _____ **Last Name:** _____

Date of Birth: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Occupation: _____ **Work Phone:** _____

E-mail: _____ **Home Phone:** _____

How did you hear about us: _____

Emergency Contact Person: _____

Relationship: _____ **Phone:** _____

What method of payment is best for you? ❑ Financing ❑ Credit Card ❑ Check ❑ Cash

Please indicate the services and areas of interest

Laser Hair Removal

Area of Interest	Hair Color	Current Method of Hair Removal

Skin Rejuvenation

Skin Tone	Firmness & Elasticity	Texture
❑ Uneven Skin Color	❑ Wrinkles ___Deep ___Fine	❑ Leathery Texture
❑ Sun Damage	❑ Lip Lines	❑ Acne Scarring
❑ Age Spots	❑ Crows Feet	❑ Large Pores
❑ Freckles	❑ Nasolabial Lines	❑ Blackheads
❑ Broken Capillaries	❑ Skin Tightening	❑ Dry/Rough Skin
❑ Rosacea	❑ Loss of Firmness/Elasticity	❑ Stretch Marks

Area of Interest	Area of Interest	Area of Interest

Cellulite Reduction / Body Contouring / Circumferential Reduction

Area of Interest	Area of Interest	Area of Interest
❑ Thighs	❑ Abdomen	❑ Arms
❑ Buttocks	❑ Hips	

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Skin Type Assessment

Please circle the appropriate answers on this form so we can properly assess your skin type

Name: _____ **Heritage:** _____

Genetic Disposition

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Green	Gray	Blue	Dark Brown	Brown/Black
What is your natural hair color?	Sandy Red	Blonde	Chestnut/Dark Blonde	Dark Brown	Black
What is the color of your skin?	Reddish	Very Pale	Pale	Light Brown	Dark Brown
Do you have freckles?	Many	Several	Few	Incidental	None
				Total	

Reaction to Sun Exposure

Score	0	1	2	3	4
What happens when overexposed to the sun?	Redness/Blistering/Peels	Blistering/Peeling	Burns Sometimes/Peels	Rarely Burns	Never Burns
To what degree does your skin turn brown?	Hardly/Not at all	Light Color Tan	Medium Tan	Tans Easily	Turn Dark Brown Quickly
Do you turn brown within several hours after sun	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very Sensitive	Sensitive	Normal	Very Resistant	No Problem
				Total	

Tanning Habits

Score	0	1	2	3	4
When was your last exposure to sun, lamps or cream?	More than 3 months	2 to 3 months	1 to 2 months	Lesss than 1 month	Less than 2 weeks
Was the treatment area exposed?	Never	Hardly Ever	Sometimes	Often	Always
				Total	

Heritage

For each Parent of African American or East Indian add 10 points	10 20
If your heritage is Latin American, Asian-Pacific Islanders, Mediteranean, or native or indigenous to the Americas add 5 points	5
Total	

Summary

Total for Genetic Disposition	
Total for Reaction to Sun Exposure	
Total for Taning Habits	
Total for Heritage	
Skin Type Score	

***Suntanned skin overrides the skin type score.**

Skin Type Score	Skin Type
0 to 8	I
9 to 16	II
17 to 24	III
25 to 30	IV
31 to 34	V
35 and over	VI

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Client History

Client Name: _____ **Date of Birth:** _____

Do you have or have you ever had any of the following conditions:

Yes	No	Medical History	Please Specify
❑	❑	Seizures and/or Epilepsy	
❑	❑	Diabetes	
❑	❑	Numbness in the area	
❑	❑	Autoimmune Disorders	
❑	❑	Sarcoidosis	
❑	❑	Lupus	
❑	❑	Scleroderma	
❑	❑	Skin Disorders	
❑	❑	Vitiligo	
❑	❑	Keloid/Hypertrophic Scarring	
❑	❑	Present Scarring	
❑	❑	Herpes Virus/Cold Sores	
❑	❑	Polycystic Ovarian Syndrome	
❑	❑	Blood clots/Phlebitis/Bleeding Disorders	
❑	❑	Peripheral Vascular Disease	
❑	❑	Lymphedemia	
❑	❑	Varicose Veins	
❑	❑	Pregnancy/Actively trying to get prgnant	
❑	❑	Cancer and/or precancerous lesions	

Yes	No	Medical Clearance Letter Required	Please Specify
❑	❑	HIV/AIDS	
❑	❑	Multiple Sclerosis	
❑	❑	Chemotherapy/radiation therapy	

Yes	No	Surgical History	Please Specify
❑	❑	Pacemakers/internal pacing devices	
❑	❑	Internal Metal Devices (rod,plates,screws)	
❑	❑	Hip Replacements	
❑	❑	Lymph Node Removal	
❑	❑	Hernias	
❑	❑	Past Surgeries	

Yes	No	Medication History	Please Specify
❑	❑	Current Medications	_____
❑	❑	Over-the-counter medications	_____
❑	❑	Herbal Supplements	_____
❑	❑	Retin-A or Generics	_____
❑	❑	Blood Thinner (Coumadin, Aspirin)	_____
❑	❑	Acne Medication	_____
❑	❑	Oral Contraceptives	_____
❑	❑	Accutane	_____ Date:_____
❑	❑	Antibiotics	_____ Date:_____

Yes	No	Allergies	Please Specify
❑	❑	Food Allergies	_____
❑	❑	Medication Allergies	_____
❑	❑	Latex Allergies	_____

Yes	No	Other	Please Specify
❑	❑	Permanent Make-up	_____
❑	❑	Tattoos	_____
❑	❑	Recent Cosmetic Procedures	_____ Date:_____
❑	❑	Botox/Restylane/Dermal Fillers	_____ Date:_____

Product Use

_____

_____

_____

_____

_____

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_____

Type of Skin	❑ Dry	❑ Normal	❑ Oily	❑ Combination	❑ Acne-prone

I have answered all the questions truthfully and to the best of my knowledge.

Client Signature: _____ **Date:** _____