HOLISTIC SKINCARE CONSULTATION

Name_____

Birthdate: _____ Age: _____ Gender: M/F

Family Physician: _____ Date of last physical exam: _____

Height: _____ Weight: _____ Goal weight: _____

Address:

_____

_____

Phone: _____ Email: _____

In case of an emergency notify:

_____

How did you hear about us?

_____

Are you currently under the care of a dermatologist or are you currently on any skin medications (oral or topical) prescribed or over the counter? Y/N

_____

_____

_____.

Please list any health issues that you have been diagnosed with, the diagnosis, as well as the date and onset below.

_____

_____

_____.

Please list any prescribed drugs, over-the-counter drugs, including vitamins or inhalers, and recreational drugs.

Medication/Supplement	Dosage/Frequency	Date started/Reason

Please list any allergies to foods, medications, supplements, herbs, environmental etc.

Allergy	Reaction

FAMILY HEALTH HISTORY

(Please list all family health history)

SURGERIES/HOSPITALIZATIONS

Year	Reason	Outcome?

PERSONAL HEALTH HISTORY

ENERGY

How would you rate your energy level on a scale of 1 to 10? 10 = vibrant and highly energetic. 1 = lethargic, brain fog, and/or low concentration 1 2 3 4 5 6 7 8 9 10

Does your energy fluctuate throughout the day? If yes, please explain:

_____

_____.

Do you have problems concentrating or finishing tasks? Y/N Explain:

_____.

LIFESTYLE

Do you wake up refreshed? Y/N

How many hours of sleep do you average per night? _____

Do you sleep soundly through the night without getting up? Y/N How many hours of naps do you average per day? _____

What do you do for relaxation/recreation? _____

How many hours per week do you allow for relaxation/relaxation? _____

Do you consider your general health to be EXCELLENT/ GOOD/ FAIR/ POOR (please circle). Explain.

_____

_____.

MENTAL/EMOTIONAL

(Please Circle)

Is stress a major problem for you? Y/N

Do you feel depressed? Y/N

Do you panic when stressed? Y/N

Do you have problems with eating or your appetite? Y/N

Do you cry frequently? Y/N

Do you have trouble sleeping? Y/N

What is your general outlook on life? Explain:

_____

_____.

EXERCISE

Do you exercise? Y/N

What kind of exercise? _____

How many times a week and for how long? _____

DIET

Are you dieting? Y/N (If yes please give name) Is it prescribed? Y/N

Of meals you eat in an average day. _____

Do you eat fast or processed food? Y/N (If yes, how many times per week) _____

How important is Organic/Natural to you? _____.

What is the source of your drinking water, and how many ounces do you drink per day?

_____.

What does a typical day of eating look like?

Breakfast	Lunch	Dinner	Snacks	Liquids

Please circle the level of intake for the following:

Caffeine: LOW /MED/ HIGH

Alcohol: LOW /MED/ HIGH

Tobacco: LOW /MED/ HIGH

Drugs: LOW /MED/ HIGH

Salt: LOW /MED/ HIGH

Sugar: LOW /MED/ HIGH

Fermented foods: LOW / MED / HIGH

Fat: LOW /MED/ HIGH

Protein: LOW /MED/ HIGH

Carbohydrate: LOW /MED/ HIGH

Vegetable: LOW /MED/ HIGH

Fruit: LOW /MED/ HIGH

Do you have cravings for certain foods? Y/N If so, please list foods and when during the day you crave them.

_____

_____.

GI

Do you have regular bowel movements? Y/N

# of times per day? _____

What color/consistency is your bowel movement?

(Please Circle)

COLOR} Brown / Tan / Green /Red / Black

QUALITY} Regular / Soft rope / Soft / no form / Medium rope / Hard / Boulders

Excessive gas/bloating? Y/N

Constipation? Y/N

Diarrhea? Y/N

Heartburn/ indigestion? Y/N

Stomach pains? Y/N

GYNECOLOGICAL

Are you post-menopausal? Y/N If yes, at what age did you enter menopause? _____

What were the characteristics of your menopausal experience?

_____

_____.

Do you currently use Hormone Replacement (HRT) or Hormonally based Contraception? Y/N

Are you now or in the near future, planning to become pregnant? Y/N

Is your menstrual cycle regular? Y/N

Longer than 28 days? Y/N

Is your flow longer or shorter than 5 days? Y/N Do

you have cramps or clotting Y/N?

Do you experience PMS, cyclical headaches, or cravings? Y/N

SKIN

What skincare products do you use on your face?

_____

_____

_____

Do you use any products with Retinol, Retin-A, or Retinoids? Y/N

How often do you wear sunscreen? _____ Do you or have you had any of the following skin issues recently?

(Please Circle)

Skin eruptions / Cold sores / Itching / Hives / Oiliness / Dryness / Acne / Rosacea / Redness / Varicose veins / Bruise easily

What are the top three skin issues/goals you would like to address today?

1.) _____

2.) _____

3.) _____

What does beauty feel/look like to you?

_____

_____.

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes. I understand that my evaluations, and/or recommendations received from Stefanie Juon, ND (Holistic Beauty Doc, LLC), are not intended as diagnosis, prescription, or treatment for any disease, physical or mental. It is also not intended as a substitute for a dermatologist or regular medical care.

Client:

Date: ____/____/____

Signature:

_____

Practitioner:

Date: ____/____/____

Signature:

_____

Skin Questionnaire

What Products do you currently use?

(Please check)

Cleanser/Serum/Toner/Day moisturizer/Night cream/Masks

What best describes your skin tone?

(Please Circle)

Very fair/Fair/Medium/Medium-Olive/Dark/Very Dark

DO you normally get eight or more hours of sleep?

(Please Circle)

YES/NO

How much exposure do you have to the following?

(Please Circle)

Pollution – LOW/MED/HIGH

Sun – LOW/MED/HIGH

Computer or device screens – LOW/MED/HIGH

What best describes your skin?

(Please Check)

___My skin produces oil all over my face, or in my t-zone

___My skin is oily & gets dry/tight when I use skincare products

___My skin is neither very oily nor very dry

___My skin is dry and produces little to no oil

___My skin is very dry and produces no oil

What are your top 3 skin concerns?

(Please Check)

Wrinkles/Oiliness/Brown spots (sun damage or discoloration)/Post-Breakout Scars/Age Prevention/Loss of Tone/Acne or Blemishes/Sensitivity (redness or rosacea)/Dryness (tight, dry, or flaky)/Under Eye (puffiness or dark circles)/Clogged Pores or Blackheads/Large Pores

How sensitive is your skin?

1=Not at all sensitive

5=Very sensitive

(Please Circle)

1 2 3 4 5

How firm would you consider your skin?

1=lacks tone and firmness

5=very firm and youthful

(Please Circle)

1 2 3 4 5

How often do you experience acne breakouts?

1=Rarely

5=Regularly & severely

(Please Circle)

1 2 3 4 5

Ninth Amendment Declaration

ARTICLE IX, U.S. CONSTITUTION

'The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."

Under the Ninth Amendment to the Constitution of the United States of America, I retain the right to freedom of choice in health care (or psychological services, or educational services. This includes the right to choose my diet, and to obtain, purchase and use any therapy, regimen, modality, remedy or product recommended by the therapist, doctor or any practitioner of my choice.

The enumeration in this declaration of these rights shall not be construed to deny or disparage other rights retained by me, or my right to amend this declaration at any time.

CONSTRUCTIVE NOTICE

Notice is hereby given to any person who receives a copy of this Declaration and who, acting under the color of law, intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this declaration, that they may be in violation of my civil and constitutional rights, Title 42, U.S.C. 1983 et seq. and Title 18, Section 241.

Client:

Date: ____/____/____

Signature:

_____

Practitioner:

Date: ____/____/____

Signature:

_____

PROVIDERS DECLARATION OF NINTH AMENDMENT RIGHTS

ARTICLE IX, U.S. CONSTITUTION

"The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the People."

I, the undersigned, hereby declare and retain the following natural and God-given rights under Article Amendment ix of the Constitution of the United States of America:

1.) The right to obtain an education from any institution or private school, including those whose views are different from conventional practice of healing, or education.

2.) The right to practice nutrition counseling (or other work) for the benefit of my clients without being required to obtain a license from any governmental authority, and to do so in a manner consistent with my training and background.

3.) The right to provide products, regimens, modalities and services to anyone for any benefit or purpose providing:

a. I shall not provide any service that I am not qualified to provide based on my experience and education;

b. I shall make no false representation(s) about my education and training experience;

c. I shall make no intentionally exaggerated, false or misleading claims for the health products and services that I provide;

d. I shall inform anyone(s) to whom I provide products and services when the protocol or regiment is experimental;

e. I shall avoid claiming that someone was "cured" of an illness unless the disease remains in remission for five years or longer;

f. All person(s) will be advised in a "Client Request and Authorization Form" to seek a second evaluation from a medical doctor, unless they have already done so.

4) I retain the right to provide customer references upon request.

5) I retain the right to use testimonials.

6) I retain the right to provide information on the intended purposes and benefits of my products and services. The health and well-being of my clients shall be my sole concern. All clients will be given a copy of this Health Care Provider's Notice at the time of initial consultation.

7) All rights retained herein are declared retroactive to the date of my 18th birthday.

The enumeration, in this declaration, of these rights shall not be construed to deny or disparage others retained by me, or my right to amend this declaration at any time. These rights, which are asserted for reasonable and good cause, are declared to be retained by the people under the Ninth Amendment to the Constitution, all state and federal laws to the contrary notwithstanding. In any litigation brought by any party objecting to the rights declared herein, a jury, representing the people, shall have the right to modify, nullify, or expand upon the Ninth Amendment rights claimed in this document.

Notice is hereby given to any person(s) who, acting under the color of law, intentionally interferes with the free exercise of the rights retained by me under the Ninth Amendment, as enumerated in this declaration, that they may be in violation of my civil and constitutional rights, Title 42, U.S.C. 1983 et seq. and Title 18, Section 241.

Client:

Date: ____/____/____

Signature:

_____

Practitioner:

Date: ____/____/____

Signature:

_____

Skin Patch Test Education

How to perform your skin patch test

Patch testing is a method of testing a new skin care product or a new skin care ingredient to see if it will work for your unique skin. Patch tests are very important because they help you avoid possible adverse reactions to new ingredients or products. They are especially helpful for people who have allergies or very sensitive skin.

PROCEDURE:

- Be sure the area of skin on which you will be performing the test is washed, dry and clean.
- Apply a small amount of item you are testing on the upper part of your inner arm (at the crook of the elbow).
- Cover it with a bandage.
- Choose a time of day where you can leave the patch test in place for least 24 hours without getting it wet.
- If you are sensitive to any of the ingredients, a reaction such as reddening, burning, itching, or other irritation, should occur within twenty-four hours of application.
- If you feel any irritation or reaction, remove the bandage immediately and wash area with soap and water.
- If you don't see or feel any reaction, the preparation is probably safe to use.

WHAT IS PATCH TESTING LOOKING FOR?

Patch testing is a way of identifying a substance that causes contact dermatitis (inflammation of the skin). There are two types of contact dermatitis: *irritant contact dermatitis and allergic contact dermatitis.*

Irritant contact dermatitis: An irritant reaction does not involve the immune system. It is most pronounced immediately after the patch is removed and fades over the next day. Although a substance that causes an irritant reaction may exacerbate skin conditions such as eczema, the reaction will not get worse with repeated exposure to the irritant.

Allergic contact dermatitis: An allergic reaction is due to substance called an allergen and occurs only in those who are allergic to that particular substance. These reactions involve the immune system. Note: since an allergic reaction may take a few days to develop, if you are an allergic type person it is important to keep an eye on the patch area for a few days after the patch is removed before using the product. A substance that causes an allergic reaction should be avoided completely. The more times the skin is exposed to the substance, the worse the allergic reaction can become.

I am aware of the information contained in this article. I understand and agree to perform a skin patch test upon receiving and using any skincare products for my personal use.

All Hydro-Line products are for external use only. Please read ingredients before use. Possible signs of allergy or skin reaction or sensitivity may occur despite all products being made with natural ingredients Stefanie Juon, ND (Holistic Beauty Doc, LLC) is not responsible nor be liable for any injuries or body reaction both internal or external, if developed.

Client Signature:

Date: ____/____/____

Signature:

_____