DMK

Danné Montague-King®

CLIENT RECORD / CONFIDENTIAL ANALYSIS

All information collected for the benefit of treatments. Your details are kept strictly confidential at all times.

CLIENT DETAILS

DATE OF FIRST VISIT:

First Name: ____ Last Name: ____

Street/PO Box: ____

City: ____ State: ____ Zip: ____

Shipping Address: ☐ Same as above

Street/PO Box: ____

City: ____ State: ____ Zip: ____

Phone: (H) ____ (W) ____

(M) ____ (F) ____

Email: ____

Occupation: ____ DOB: ____

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Other

Referred By: ____

SKIN

Check the areas of concern you would like to improve in your skin:

☐ Color ☐ Firmness ☐ Chest/ decolleté ☐ Dryness

☐ Texture ☐ Capillaries ☐ Blackheads ☐ Pore size

☐ Freckles ☐ Plumpness ☐ Breakouts ☐ Congestion

☐ Wrinkles ☐ Smoothness ☐ Acne ☐ Scarring

☐ Eye area ☐ Neck area ☐ Premature aging

List the skin care products you are currently using: ____

Have they achieved the results you want? ☐ No ☐ Yes

Do you use sunscreen daily? ☐ No ☐ Yes

BODY

Check the areas you would like more information on or are interested in:

☐ Cellulite ☐ Weight loss

☐ Body sculpting/Firming ☐ Stretch marks

☐ Scarring/pigmentation ☐ Ingrown Hairs

☐ Alternative hair removal ☐ Heavy Callouses & Cracked Feet

List the body care products you are currently using: ____

Have they achieved the results you want? ☐ No ☐ Yes

MEDICAL HISTORY

Have you in the past or present or had any of the following problems?

☐ Epilepsy ☐ Hysterectomy

☐ Diabetes ☐ Hormonal Imbalance

☐ Thyroid ☐ Depression

☐ Heart Problems ☐ High or Low Blood Pressure

☐ Cancer ☐ Other ____

Have you had plastic surgery? ☐ No ☐ Yes

Did it achieve the results you want? ☐ No ☐ Yes

Date: ____ Surgeon's Name: ____

Description: ____

Are you currently using Retin-A, Retinal, AHA or any peeling agent? If so:

How Long: ____ Strength: ____

Results: ____

Do you suffer from claustrophobia or anxiety? ☐ No ☐ Yes

Do you have any known allergies to cosmetics, food, medication, animals, pollens, or metals?

____

Do you have a tendency to keloid scar? ☐ No ☐ Yes

Have you had a skin peel in the past 2 years? ☐ No ☐ Yes

Results: ____ Brand: ____

MEDICATION

Have you been under a physician's care during the past 3 years? ☐ No ☐ Yes

Are you currently taking medication? ☐ No ☐ Yes

How long: ____ Name: ____

Are you currently taking Accutane or Roaccutane? ☐ No ☐ Yes How long: ____

Dietary or Herbal Supplements or Vitamins? ☐ No ☐ Yes

How long: ____ Name: ____

How much water, coffee/tea (caffeine) do you drink daily?

☐ Water ____ ☐ Caffeine ____ ☐ Alcohol ____

Client Signature ____

Certifies above is correct

Date ____

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CLIENT: First Name ______________________ Last Name ______________________

PARAMEDICAL ANALYSIS BY THERAPIST

The skin at the time of consultation visually presents with:

	Date	Date	Date	Date
☐ Oil Flow				
☐ Skin cell build up				
☐ Thinning of skin				
☐ Fine lines and wrinkles				
☐ Milia				
☐ Capillaries				
☐ Congestion				
☐ Acne				
☐ Environmental damage				
☐ Passive pigmentation				
☐ Inflammatory pigmentation				

TREATMENT PROGRAM

Objectives

Recommended Home Prescriptives (check categories)

- ☐ Cleanse
- ☐ Serum
- ☐ Spray
- ☐ Supplements
- ☐ Cream
- ☐ Specialty Masks

HOME PRESCRIPTIVES DETAILS

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CLIENT: First Name ______ Last Name ______

CLIENT HISTORY / CONFIDENTIAL ANALYSIS

Date	Treatment Details	Date	Treatment Details

Facial Notes

Right side ______

T-zone ______

Left side ______

Photo Record