

Client Skin Analysis/Evaluation Form



Name: _____ Date of Consult: _____

Address: _____ Age: _____ Gender: _____

City: _____ State: _____ Zip: _____

Known Allergies: _____

Medications: _____

| Skin Classification | |
|---|---|
| Fitzpatrick Classification: | Type I Type II Type III Type IV Type V Type VI |
| Normal _____ | Scars (acne, etc) _____ |
| Dry _____ | Photoaging _____ |
| Dehydrated _____ | Wrinkles _____ |
| Mature _____ | Superficial lines _____ |
| Thin, sensitive skin _____ | Deep lines _____ |
| Oily _____ | Relaxed elasticity _____ |
| Open pores _____ | Good elasticity _____ |
| Comedones (blackheads) _____ | Couperose (broken capillaries) _____ |
| Milium (whiteheads) _____ | Dilated capillaries _____ |
| Asphyxiated (blocked pores and follicles) _____ | Discolorations _____ |
| Blemishes/Acne _____ | Other: _____ |
| How many years? _____ | _____ |
| Vulgaris: <input type="radio"/> No <input type="radio"/> Yes Chronic: <input type="radio"/> No <input type="radio"/> Yes | _____ |
| Cystic: <input type="radio"/> No <input type="radio"/> Yes Rosacea: <input type="radio"/> No <input type="radio"/> Yes | _____ |

Date: _____ Skin Care Professional: _____

Specific Concerns: _____

Type of treatment: _____

Notes/Remarks: _____

Recommended Home Skin Care Products:

For Daytime:

For Nighttime:

