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 _____
Dry_____
Dehydrated_____
Mature _____
Thin, sensitive skin _____
Oily _____
Open pores _____
Comedones blackheads)_____
Milium (whiteheads)_____
Asphyxiated (blocked pores and follicles) _____
Blemishes/Acne_____
How many years? _____
Vulgaris: m No m Yes Chronic: m No m Yes Cystic: m No m Yes Rosacea: m No m Yes

Scars (acne, etc)_____
Photoaging_____
Wrinkles _____
Superficial lines_____
Deep lines_____
Relaxed elasticity_____
Good elasticity_____
Couperose (broken capillaries)_____
Dilated capillaries_____
Discolorations _____
Other:_____
_____
_____
_____

Date: _____ Skin Care Professional: _____

Specific Concerns: _____

Type of treatment: _____

Notes/Remarks: _____

Recommended Home Skin Care Products:

For Daytime:

_____
_____
_____
_____

For Nighttime:

_____
_____
_____
_____