Discovery File

Help us better understand your needs Date:_____

Name:_____

What Are Your Concerns?

Face

___ Wrinkles & Fine Lines___ Wrinkles & Fi

___ Acne

___ Redness

___ Sensitivitiy

___ Excessive Oil/Shine

___ Skin Discomfort (Dehydration)

___ Pigmentation Spots

___ Comedones

___ Dull Skin Tone

___ Ingrown Hair

___ Loss of Skin Firmness

Other _____

Eyes & Lips

___ Chapped Lips

___ Lines around the Lips

___ Loss of Firmness

___ Wrinkles & Fine Lines

___ Sensitivity

___ Dark Circles

___ Puffy Eyelids

Other_____

Hands & Feet

___ Brittle Nails

___ Pigmented Spots

___ Cracked Hands

___ Cracked Heels

Other_____

Body

___ Dry/Flaky Skin

___ Pigmentation Spots

___ Back Pain

___ Heavy, Tired Legs

___ Cellulite

___ Loss of Skin Firmness

___ Ingrown Hair

Are you currently using any of the following?

Vitamin A / RetinA/Retinol/Retinoids	Yes	No
Hydroxy Acids/ Beta Hydroxy Acids	Yes	No
Steroid Medication	Yes	No
Acne Medications/Topicals/Oral	Yes	No
Are you allergic to anything?	**Yes**	**No**
Are you Pregnant?	**Yes**	**No**