

Regenerative Youth & Beauty Plan Intake Form

READ THOROUGHLY AND EMAIL ME WITH ANY QUESTIONS IF SOMETHING IS NOT CLEAR BEFORE YOUR APPOINTMENT DATE/TIME:

Please send me at least one picture of yourself of when you felt you looked your best esthetically, and when your skin was at its best (not modified and with no filter) to the consultation. **They can be two separate pictures if these two instances were not during the same time.**

Also send a picture of yourself 10-15 years ago.

Send any inspiration images of how you'd like your skin to look

Email all images and filled out form in ONE email (as attachments) to:
connect@youthandbeautyorlando.com

Please bring your current skin care products and makeup you're actively using daily, and additional products you're still looking to use/incorporate and that you know you love.

Write down all questions before the consultation and come prepared for your hour.

A follow up consult can be scheduled (virtually or in person) for an additional \$100 (up to 1 hour but could be less).

Although I sell some skin care products, I may or may not recommend these in combination with other products I do not personally sell. Depending on your goals, your skin, the season, your current skin condition (based on environment, season, health, etc), what I recommend will depend on every factor considered. These recommendations will most likely be different in a future consultation with some (or possibly all) of the products I may have recommended in the past.

Any treatments you have done based off my recommendation (that I perform in my Non-Surgical Youth & Beauty Clinique), will receive a 10% credit towards each service.

All questions are relevant to the overall picture of your skin's health and the aging process. Please answer honestly and to the best of your ability. There is no judgment. The more accurate and truthful you are, the better picture I get and the more I can help you, which means you benefit more from my recommendations. All information is kept confidential.

Name _____ DOB _____

Age _____ Email _____ Phone _____

Address _____

What is your ethnic background? _____

Do you:

- (0) Always burn, never tan, blisters and peels __
- (1) Usually burn, tans with difficulty, blisters and peels __
- (2) Somewhat mildly burns and then tans __
- (3) Rarely burns, if at all, tans easily __
- (4) Never burns __

(Office use only: Fitzpatrick Type ____)

What is your natural color before sun exposure? (the skin covered by your bathingsuit is the best indicator for this):

- (0) Ivory/white __
- (1) Fair/pale __
- (2) Fair to beige with golden undertone __
- (3) Olive or light brown __
- (4) Dark brown or black __

What is your natural hair color?

- (0) Red or light blonde __
- (1) Blonde __
- (2) Dark blonde/light brown __
- (3) Medium to dark brown __
- (4) Black

What is your natural eye color?

- (0) Light blue, light gray or light green __
- (1) Blue, gray or green __
- (2) Hazel or light brown __
- (3) Dark brown __
- (4) Black __

Medical

List all your current medication

List your current health conditions / illnesses

Past health conditions and surgeries (please include dates)

Esthetic

What esthetic procedures have you had done? (including past cosmetic surgeries, devices, lasers, injectables, etc.)

What results were you looking for in doing these procedures. What did you want to address?

Do you have pictures of yourself before and after? If so, please email to me.

Were you disappointed in the procedures or do you have any regrets? Please explain

If you haven't already, would you ever get injectables? (filler, Botox, etc) ____

If you haven't already, would you ever get laser treatments? ____

If you haven't already, would you ever get medical grade peels? ____

If you haven't already, would you ever have plastic surgery done? (facelift, liposuction, etc) ____

Please explain further if you

wish: _____

Lifestyle

Do you drink soda? _____ If yes, how many cans a day/week? _____ Are they diet or regular? _____

Are you sweet or savory? _____

What is/are your favorite thing/s to eat?

Give me an example of what you eat in a day (breakfast, lunch, dinner and any snacks)

Do you tend to get bloated after eating? __ Do you tend to have stomach issues after eating (pain, cramps)? __

If so, after what kinds of foods?

Do you have any issues going to the bathroom? __

Do you exercise? ____ If yes, what kind of exercise? _____

How many days a week? _____

Do you feel good in your body? _____

Do you drink alcohol? __ If so, how many drinks in a week? _____ Wine, beer, spirits? _____

Do you smoke? ____ If so, how many cigarettes in a day? _____

How long have you been smoking? _____ years

Do you drink coffee? ____ If yes, how many in a day? _____

What else do you do to stay on top of your health? (Examples: regular check ups with your doctor, meditation, massage, supplements, juicing, etc)

Do you like to be out/lay out in the sun? _____ Do you wear sunblock daily? _____

Circle everywhere you apply SPF daily: face – neck – décolletage/chest – eyes – ears – arms - hands

How often and how many hours in a day?

Do you wear sunblock on your body when you lay out? _____ If not, how come?

Please list all allergies (food/ingredients/etc)

Do you take collagen? ____ Do you take vitamins/supplements? __ Please list:

What changes would you like to see in your skin?

What changes would you like to see in your face and/or body?

How many hours average do you sleep a night? _____ What is your average bed time? _____

What is your average wake up time? _____ Do you take naps? _____

What is your stress level on a scale of 1-10 (1= No stress at all, 5= Stress at work but not personal life, 10=Stress all the time in every area of life) _____

If you wish to share, what are the current stressors in your life?

Is the stress situational/temporary? _____

Are you willing to make basic changes to your lifestyle or diet if necessary for better results? _____

What will never change? _____

How committed are you to this on a scale of 1-10? (Be honest please! I can only work with what is realistic for you, not what you think the ideal answer should be. We can honor where you are. There are no expectations) _____

What can you not live without/what are deal breakers?

What do you love to do/what brings you absolute joy?

What do you do to relax or calm yourself down?

Thank you and I look forward to working with you! Your answers are confidential and are only used to help me understand who you are as a whole to better serve and guide you in the changes you'd like to see in your youth and beauty goals.

I have thoroughly read and understood all the questions and have answered truthfully to the best of my ability. If I had questions, I asked and received clarification. I also understand that specific results cannot be guaranteed, and my participation in how I care for myself, follow advice given and follow after care instructions plays a big impact in the overall results.

Name

Date

Signature