

# Client Skin Analysis/Evaluation Form



Name: \_\_\_\_\_ Date of Consult: \_\_\_\_\_

Address: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

<b>Skin Classification</b>						
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:	<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:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_