

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? | _____ | | | | | | _____ |
| | | | | | | | _____ |
| | | | | | | | _____ |
| | | | | | | | _____ |
| | | | | | | | _____ |
| | | | | | | | _____ |
| | | | | | | | _____ |

Date: _____ Skin Care Professional: _____

Specific Concerns: _____

Type of treatment: _____

Notes/Remarks: _____

Recommended Home Skin Care Products:

For Daytime:

For Nighttime:

