For any statement that applies to you, circle the number in the related row. Add columns to calculate your total.

BRILLIANT
Body Assessment

	Digestive	*Hepatic*	*Intestinal*	*Circulatory*	*Nervous*	*Immune*	*Respiratory*	*Urinary*	*Glandular*	*Structural*
illness more than twice a year						3	3			
Body odor and/or bad breath	1		3				1	1		
Difficulty digesting certain foods	3	2				1				
Less than 3 servings of fruits and vegetables a day	1		2	1		2		1		
Monthly female concerns		2	1					1	3	
Recent or frequent use of antibiotics			2			3	1			
Regular consumption of alcohol		5			1				1	
Gum problems or redness of the nose				2						
Food allergies	3	2				1	2			
Puffiness under eyes								3		
Smoking		1		3	2	2	5			
Poor concentration or memory				2	1				1	
Heavy coating on tongue	3		1			1	1			
Belching or gas after a meal	3		1							
Stressful lifestyle				3	2	2			1	
Skin/complexion problems		2	2					2	1	2
Cravings for sweets or junk food						1			2	
Daily consumption of dairy products			2				2			
Feeling down, uninterested or moody		3	1		3				1	
Difficulty getting to sleep, lack of sleep		2			1				1	
Menopausal problems		1			1				1	2
Frequent urination or urinary concerns								4		
Age-related health problems	1			2		1			1	2
Sore or painful joints			1			1		1		3
Difficulty maintaining ideal weight	1				1			1	1	
Lack of energy or endurance				1		2	1		1	
Diet high in meat and grains	1		2	1				3		1
Heavy mucus production or feeling congested	1		1				2			
Fewer than two bowel moments per day	1	1	3		1		1			
Weak knees, ankles or back								2		3
Low sex drive				1	1				2	
Brittle or easily broken finger nails	1									2
Dry, damaged or dull hair	1								1	2
Daily consumption of fried foods	1	2		3	1					
Frequently feeling fearful or timid					2			2	1	
Cold hands and/or feet				3					1	
Muscle cramps or spasms					2					1
Exposure to air pollution daily						1	2			
Daily consumption caffeinated beverages					1				1	2
Shallow or difficult breathing						1	2			
Restless sleep or waking up frequently		2			1			1	1	
Recurrent yeast or fugal infections	1		2			2	1	1		
Weak bones, teeth or cartilage	1							2		3
Feeling anxious or worried	1				3				1	
Feeling irritable or easily angered		2		1	1				2	
Don't exercise regularly				2						2
Respiratory concerns			1			1	3			
Total Points Possible	27	25	25	25	25	27	25	25	25	25
MY TOTAL POINTS BY BODY SYSTEM										

Pura Derma Skin Care

Confidential Health Questionnaire

"Your skin is the fingerprint of what is going on inside your body, and all skin conditions, from psoriasis to acne to aging, are the manifestations of your body's internal needs, including its nutritional needs."
- Dr. Georgiana Donadio, founder - National Institute of Whole Health

Name: ____ Date of Birth: _____________ Age:_________

Address: ____City ________________________Zip__________

Home Phone: _____________________Work Phone:____________________ Cell: ______________________

Emergency Contact: _______________________________________ Phone: ____________________________

E-Mail Address:____

Would you like to receive our monthly e-newsletter and specials? __Yes __No

Would you like your significant other to be notified of Pura Derma gift giving possibilities for your birthday and holidays? ___Yes ___ No e-mail address:____

General Health

Have you been under the care of a physician, dermatologist or other medical professional within the past year? ___No ___Yes, explain:____

Any recent surgery, including plastic surgery? ___No ___Yes, explain: ______________________________

Any skin cancer? ___No ___Yes, explain:____

Have you had any of these health conditions in the past or present?

__Cancer	__Hormone imbalance	__Immune disorders
__Systemic disease	__High blood pressure	__HIV/AIDS
__Spinal injury	__Thyroid condition	__Lupus
__Hysterectomy	__Diabetes	__Metal bone pins or plates
__Heart problem	__Varicose veins	__Blood clotting abnormalities
__Arthritis	__Asthma	__Keloid scarring
__Eczema	__Epilepsy	__Insomnia
__Seizure disorder	__Fever blisters	__Any active infection
__Headaches (chronic)	__Hepatitis	__Skin disease/skin lesions
__Herpes	__Frequent cold sores	__Phlebitis, blood clots, poor circulation
__ Neck Injury	__ Poor circulation	__ Active Infection

Beautiful healthy skin is a reflection of your internal health. Are you interested in a Brilliant Body Health Assessment to evaluate the state of your internal health? ___ No ___ Yes

Do you have allergies? ___ No ___ Yes, explain____

Have you ever had an allergic reaction to any of the following?

___ Cosmetics ___ Medicine ___ Food ___ Animals ___ Sunscreens ___ Iodine ___ Pollen

___ AHAs ___ Fragrance ___ Shellfish ___ Latex ___Drugs Other ___________________

Lifestyle

Do you follow a restricted diet? __No __Yes, specify: ____

Do you follow a regular exercise program? __No __Yes

What is your current stress level? ___ High ___ Medium ___ Low

What is your normal stress level? ___High ___ Medium ___Low

List your daily consumption of: Water ____________ Caffeine ____________ Alcohol _____________

Do you smoke? ___No ___Yes Live with a smoker? __No __Yes

Do you experience any problems sleeping? ___No ___Yes

How many hours do you typically sleep each night? __________

Do you wear contact lenses? ___No ___Yes

Medications

List prescription medications and over the counter medication (vitamins, herbal supplements, aspirin, etc.) you take regularly: ____

____

Female Clients

Are you taking oral contraceptives? ___ No ___Yes, specify:___________________________________

Any recent changes to your contraceptive treatment? ___ No ___ Yes, If so, what and when?__________

____

Are you pregnant or trying to become pregnant? ___ No ___ Yes

Are you lactating? ___ No ___ Yes

Are you currently on hormone replacement therapy ___No ___ Yes, specify______________________

Any menopause problems? ___ No ___ Yes, specify: _______________________________________

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: ____Date:______________

Pura Derma Skin Care

Confidential Skin Health Questionnaire

Name: ____ Date:________________________________

Have you ever had a facial treatment before? ___ No ___ Yes When was your last facial? ___________________

Where was your last facial?____

Have you ever had chemical peels, laser or microdermabrasion? ___No ___Yes In the last month? ___No ___ Yes

Have you used any of the following hair removal methods in the past six weeks? ___No ___Yes Which One:
___Shaving ___Waxing ___Electrolysis ___Plucking ___Tweezing ___Stringing ___Depilatories

Skin Type & Condition

Which of the following best describes your skin type?

____ I Creamy Complexion - Always burns easily, never tans
____ II Light Complexion - Always burns, tans slightly
____ III Light/Matte Complexion - Burns moderately, tans gradually
____ IV Matte Complexion - Seldom burns, always tans well
____ V Brown Complexion - Rarely burns, deep tan
____ VI Black Complexion - Never burns, deeply pigmented

Is your skin…
___Normal ___Dry/Dehydrated ___Combination ___Oily ___Sensitive

What concerns do you have regarding your…

Skin:
____ Breakouts/Acne
____ Blackheads/Whiteheads
____ Excessive Oil/Shine
____ Rosacea
____ Broken Capillaries
____ Redness/Ruddiness
____ Sun Spot/Liver Spot/Brown Spot
____ Uneven Skin Tone
____ Sun Damage
____ Wrinkles/Fine Lines
____ Dull/Dry Skin
____ Flaky Skin
____ Dehydrated Skin
____ Other______________________________

Eyes: ___ Dehydrated ___ Wrinkles ___ Puffiness ___ Dark Circles ___Other: ______________________

Lips: ___ Dehydrated ___Cracked/Capped Lips ___Other: ______________________________________

Do you form thick or raised scars from cuts or burns? ___ No ___ Yes

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ___ No ___ Yes Describe:____

In order of importance, please rank 1 (most important) to 5 (least important) improvement in the next 30 days:

____ Reduction of Fine Lines ____ Acne Scars Diminished ____ Reduction of Oil/Acne

____ Reduction of Brown Spots ____ Reduction of Redness

How do you feel about the overall quality of your skin?

(bad) 1 2 3 4 5 6 7 8 9 10 (fantastic)

Medications & Medical Grade Ingredients

Have you ever used: (check all that apply)

___ Retin-A ___ Hydroxyl Acid ___ Alpha Hydroxyacid Acid

___ Renova ___ Deferin ___ Salicylic Acid

___ Adapalene ___ Glycolic Acid ___ Retinol/Vitamin A derivative products

Have you used any of these products in the last 3 months? ___No ___Yes

Have you experienced Botox, Restylane or Collagen injections? ___ No ___Yes When? ___________________

specify:____

Have you used an acne medication? ___No ___Yes When? ___________ Which Drug (s)? _______________

____

Product Information & Reactions

What brand of skin care products are you currently using? ____

___ Cleanser ___ Toner ___ Moisturizer ___ Masque ___ Serum ___ Eye Crème ___ Other________________

Have you ever had an adverse reaction after using any skin care product? (Please circle any that apply)

Rash Irritation Peeling Sun Sensitivity Breakout Other____

Sun Care & Exposure

Do you use a daily Environmental Protection product (sun block)? ___No ___Yes If not, why?_________________

Have you been exposed to the sun or used a tanning bed in the last 48 hours? ___ No ___ Yes

Have you recently used any self-tanning lotions, creams or treatments? ___No ___Yes

How frequently are you exposed to the sun or use a tanning bed? ___Infrequently ___Frequently ___Regularly

What SPF do you use on your face? _____________ How often/when? ______________________________________

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: ____Date:____________________

Notes: