IVANË SKIN STUDIO

New Client Acne and Home Care Questionnaire

Your goals and acne history

Select all answers that apply. Write “unsure” when needed. Bring your products or clear photos of their labels. Your answers help us create a routine that fits your skin and daily life.

Name: _____ Date of birth: _____
Phone: _____ Email: _____
Date completed: _____

1. What are your three main skin concerns?
☐ Breakouts ☐ Blackheads / clogged pores ☐ Deep painful bumps ☐ Excess oil ☐ Dryness / tightness ☐ Redness / sensitivity ☐ Dark / red marks ☐ Indented / raised scars ☐ Uneven texture ☐ Other

2. What would you most like to improve first?

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3. How does your skin affect your confidence or daily life?

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4. When did your breakouts begin? Have they recently changed?

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5. Where do you experience breakouts?
☐ Forehead ☐ Hairline ☐ Temples ☐ Cheeks ☐ Nose ☐ Chin ☐ Jawline ☐ Neck ☐ Chest ☐ Back ☐ Shoulders ☐ Other

6. What do your breakouts usually look or feel like?
☐ Blackheads ☐ Small skin-colored / white bumps ☐ Red raised bumps ☐ Pimples with a white / yellow center ☐ Deep tender bumps ☐ Similar-looking itchy bumps ☐ Unsure

7. How often do you develop new breakouts?
☐ Daily ☐ Several times a week ☐ Weekly ☐ Occasionally ☐ Around my cycle

8. Do breakouts hurt, itch, or leave marks or scars? Describe.

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9. What seems to make breakouts better or worse?
Consider stress, your cycle, products, sweating, travel, or medication changes.

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10. Does acne run in your family?
☐ Yes ☐ No ☐ Unsure

11. What acne treatments have you tried?
Include products, prescriptions, professional treatments, duration, and results.

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Oiliness dryness and sensitivity

Client name: _____ Date: _____

12. On a typical day, how does your skin feel?
☐ Oily across most of my face ☐ Oily mainly on forehead / nose / chin ☐ Mostly balanced ☐ Mostly dry / tight ☐ Oily but also tight / flaky / dehydrated ☐ Unsure

13. How soon after cleansing does noticeable shine appear?
☐ Within an hour ☐ By midday ☐ By evening ☐ Rarely ☐ Unsure

14. Does your skin currently experience any of the following?
Where and how often?
☐ Flaking / peeling ☐ Tightness after washing ☐ Stinging with moisturizer / water ☐ Burning with products ☐ Persistent redness ☐ Cracking / raw areas ☐ None

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15. Which products or ingredients have caused a reaction? What happened?
Include benzoyl peroxide, salicylic acid, exfoliating acids, retinoids, fragrance, or sunscreen.

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16. Have you had swelling, hives, blistering, or a diagnosed skincare allergy?
Name the product and describe the reaction.
☐ Yes ☐ No

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17. Have you been diagnosed with eczema, rosacea, dermatitis, or another skin condition?

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18. How does your skin respond to sun exposure?
☐ Burns easily ☐ Sometimes burns ☐ Rarely burns ☐ Develops lingering dark marks easily ☐ Unsure

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Your current products and routine

Client name: _____ Date: _____

19. List every product you currently use.

Include exact name, strength if known, frequency, and when you started.

Product category	Name / strength / start date	Frequency
Cleanser / makeup remover		
Toner / facial mist		
Serum / exfoliating acid		
Acne / spot treatment		
Retinol / prescription topical		
Moisturizer / facial oil		
Sunscreen / SPF		
Scrub / mask / peel / device		

20. Describe your morning routine in application order.

21. Describe your evening routine in application order.

22. How often do you wash your face and remove makeup before bed?

23. Do you apply acne treatments to spots or across breakout-prone areas?

24. What makeup, hair, beard, or body products touch your breakout areas?

Include foundation, concealer, primer, conditioner, leave-ins, oils, and styling products.

25. What products have you added, stopped, or changed in the past three months? What happened afterward?

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Health medications and hormones

Client name: _____ Date: _____

This helps us assess product suitability. Do not stop or change prescribed medicines without speaking with your prescriber.

26. Are you seeing a dermatologist or clinician for your skin? What is their treatment plan?

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27. List all prescriptions, over-the-counter medicines, vitamins, supplements, and protein powders.

Include doses if known and any recent changes.

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28. Have you used isotretinoin, also known as Accutane?

Start / end dates:
☐ Never ☐ Currently ☐ Previously

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29. Are you using prescription acne creams, antibiotics, spironolactone, hormones, or steroid medicines?

Names, frequency, and last use:

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30. Are you pregnant, breastfeeding, or trying to become pregnant?

☐ No ☐ Pregnant ☐ Breastfeeding ☐ Trying to conceive ☐ Discuss privately ☐ Not applicable

31. Do breakouts change around your menstrual cycle?

Describe the timing:
☐ Yes ☐ No ☐ Unsure ☐ Not applicable

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32. Do you use hormonal birth control or hormone therapy? Have you recently started, stopped, or changed it?

Name and dates:

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33. What diagnosed medical conditions or allergies may affect skincare?

Include PCOS or other hormonal conditions if applicable.

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New Client Acne and Home Care Questionnaire

Daily habits and possible patterns

Client name: _____ Date: _____

These questions help identify individual patterns; they do not assume any habit or food causes your acne.

34. Do you pick, squeeze, scratch, or frequently touch breakouts?
☐ Never ☐ Sometimes ☐ Often

Would you like help managing this habit? ☐ Yes ☐ No

35. Do you regularly sweat, exercise, swim, or wear equipment that rubs against your skin?
Include masks, helmets, chin straps, or tight clothing. What do you do for your skin afterward?

36. Do shaving, waxing, or other hair-removal methods trigger bumps or irritation?

37. How often do you clean makeup tools and change pillowcases or face towels?

38. What is your current stress level, and how much sleep do you get?
Usual hours of sleep per night:
☐ Low stress ☐ Moderate stress ☐ High stress

39. Have you noticed a consistent relationship between breakouts and foods, drinks, or supplements?
What, how often, and what pattern have you noticed?

40. Have you recently had a facial, peel, laser, microneedling, waxing, or significant sunburn?
Treatment / exposure and date:

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New Client Acne and Home Care Questionnaire

Making your routine practical

Client name: _____ Date: _____

41. How consistently do you currently follow a skincare routine?
☐ Morning and evening ☐ Once daily ☐ A few days a week ☐ No consistent routine

42. What makes consistency difficult?
☐ Time ☐ Cost ☐ Too many steps ☐ Irritation ☐ Forgetting ☐ Unclear instructions ☐ Other

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43. What is a comfortable budget for initial products and replacements?

Initial products: $_____ Ongoing replacements: $_____

44. What sunscreen or product textures do you like or dislike?

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45. Are you comfortable following written instructions, introducing products gradually as directed, and checking in for adjustments?
☐ Yes ☐ I have questions ☐ I need a simpler plan

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46. Is there anything else you want me to know before we build your routine?

Client signature: _____ Date: _____

For a client who is a minor, parent or guardian name and signature if required:

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New Client Acne and Home Care Questionnaire

Consultation and home care planning

Client name: _____ Date: _____

For Ivanë to complete after consultation. Use client answers alongside skin assessment and the applicable professional protocol.

Observed skin type: ☐ Dry ☐ Normal ☐ Combination ☐ Oily

Current skin condition: hydration, redness, flaking, irritation, and tolerance

Breakout pattern: inflamed / noninflamed / mixed; location and severity

Post-breakout concerns: discoloration and scarring

Medication, allergy, or pregnancy considerations

Products reviewed and potential overlaps identified

Sensitivity testing: product, strength, date, and response per professional protocol

Home care plan

Record exact products, strengths, order, amounts, frequency, and introduction schedule.

Instructions: symptoms to report and how to contact the studio

Medical referral or coordination needed

Follow-up date: _____ Esthetician: _____

Independent Ivanë Skin Studio intake form; not an official Face Reality form. Product strengths and schedules require professional assessment. Coordinate prescription changes with the prescriber.