Client Consultation Form

NAME ____ DATE of BIRTH ______________

ADDRESS ______________________________ CITY _________________ STATE _____ ZIP ________

PHONE ______________________ EMAIL ____

Sex: ___ Female ___ Male

How were you referred to us? ____

Occupation: ______________________ Does your job require that you work outdoors? Yes___ No___

What would you like to achieve from your treatment today?

____

____

MEDICAL:

Are you currently or within the last year under any doctor's care? Yes___ No___

If yes, please specify:

____

____

Have you had chemotherapy in the past 6 months? Yes___ No___

Have you undergone any recent surgery? Yes___ No___

Please list vitamins and supplements including herbal remedies you take regularly - pertinent only:

____

HEALTH PROBLEMS:

___ Arthritis

___ Cardiac or Circulatory problems

___ Contagious Diseases

___ Epilepsy or Seizures

___ Heart Condition

___ Pacemaker or internal defibrillator

___ High/Low Blood Pressure

___ Psoriasis/Eczema

___ Deep Vein Thrombosis

___ Herpes Simplex

___ Cancer

___ Diabetes

___ Fungus

___ HIV

___ Autoimmune disease

___ Joint Swelling

___ Thyroid

___ Fibromyalgia

Allergies? (food, latex, topical products, and/other substances) ___________________________________

____

Is there anything else you would like us to know? ____

____

ESTHETICIAN PROFILE:

Do you have any of the following conditions?

Are you Pregnant or trying to become pregnant? Yes___ No___ /or breastfeeding Yes___ No___

Are you undergoing any hormone replacement therapy treatments? Yes___ No___

Are you taking oral contraceptives? Yes___ No___

Any recent changes to or from your contraceptive treatments? Yes___ No___

Are you experiencing any menopausal symptoms? Yes___ No___

Dental implants, crowns, metal fillings Yes___ No___

Have you experienced Botox, Restylane, or collagen injections? Yes___ No___ If yes, please specify:

____

History of skin disorders:

____

Do you have a history of Erythema Ab Igne (EAI), a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat? Yes ___ No ___

Do you blush easily? Yes___ No___

Sunburn easily? Yes___ No___

Redness tendency? Yes___ No___

Do you form thick or raised scars from cuts or burns? Yes___ No___

Areas of concern (be specific please) ____

Are you claustrophobic? Yes___ No___

Sinus problems? Yes___ No___

PERSONAL SKINCARE:

Have you ever had a facial treatment before? Yes___ No___, when? ___________

____

Do you have any special skin problems or concerns pertaining to your face or body? Yes___ No___

If yes, please specify:

____

Have you ever had chemicals peels, laser treatments? Yes___ No___

In the last month? Yes___ No___

Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative product? Yes___ No___

Have you used acne medication? Yes___ No___, when? ____________ Which medication?

____

What areas of concern do you have regarding your skin: (Check all that apply)

___ Breakouts/acne ___ Uneven skin tone ___ Blackheads/whiteheads ___ Sun damage ___ Excessive oil/shine

___ Wrinkles/fine lines ___ Rosacea ___ Dull/dry skin ___ Broken capillaries ___ Flaky skin ___ Redness/ruddiness

___ Dehydrated ___ Sun/liver/brown spots

Other: ____

(Check all that apply)

___ Dehydrated ___ Wrinkles ___ Puffiness ___ Dark circles

Other: ____

What skin care products are you currently using? (List brands if known)

Cleanser ________________________________ Toner _____________________________________

Day Moisturizer __________________________ Night Moisturizer ___________________________

Exfoliator _______________________________ Mask _____________________________________

Eye Product _____________________________ SPF/Sunscreen ____________________________

Scrubs _________________________________ Makeup Products____________________________

Soap ___________________________________ Shower Gels ______________________________

Body Lotions _____________________________

Have you used any hair removal methods in the past six weeks? Yes___ No___

(Check all that apply)

___ Shaving ___ Waxing o Electrolysis ___ Plucking ___ Tweezing ___ Stringing ___ Depilatories ___ Other

FUTURE APPOINTMENTS/CONTACT

May I call you at the provided phone number to confirm future appointments? Yes___ No___

May I contact you via mail/email about future promotions and news? Yes___ No___

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 the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Client Name (Printed): ____

(Signature): ____ Date: ______________________

Therapist signature: ____

Date: ____