Client Consultation

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

Single: ❍ No ❍ Yes Married: ❍ No ❍ Yes If yes, anniversary date: _____

Employer: _____ Occupation: _____

Does your job require that you work outdoors? ❍ No ❍ Yes

Referred by: _____

What would you like to achieve from your treatment today? _____

Your Skin Care

1) Have you ever had a facial treatment before? ❍ No ❍ Yes, when? _____

2) Have you ever had a body spa treatment before? ❍ No ❍ Yes, when? _____

Massage:	❍ No ❍ Yes
Salt glow:	❍ No ❍ Yes
Seaweed wrap:	❍ No ❍ Yes
Moor mud:	❍ No ❍ Yes
Body scrub:	❍ No ❍ Yes
Other: _____	

3) Which of the following best describes your skin type? (Please circle one type number)

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	Dark Brown Complexion	Rarely burns, deeply pigmented

4) Do you have any special skin problems or concerns pertaining to your face or body? ❍ Yes ❍ No

specify: _____

5) Have you ever had chemical peels, laser or microdermabrasion? ❍ No ❍ Yes In the last month? ❍ No ❍ Yes
6) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? ❍ No ❍ Yes

describe: _____

Continued ⇨

7) Have you used any of these products in the last 3 months? ❍ No ❍ Yes

8) Have you used an acne medication? ❍ No ❍ Yes, when? _____ Which drug? _____

Soap _____
Toner _____
Mask _____
Eye Product _____
Cleanser _____
Day Moisturizer _____
Exfoliator _____
Scrubs _____

Shower Gels _____
Body Lotions _____
Sunscreen _____
SPF _____
Night Moisturizer/Cream _____
Other _____
Makeup Products _____
_____

9) What skin care products are you currently using? (List brand where known)

10) Have you recently used any self-tanning lotions, creams or treatments? ❍ No ❍ Yes, specify: _____

11) Have you used any of the following hair removal methods in the past six weeks? ❍ No ❍ Yes, circle all that apply.

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

12) What areas of concern do you have regarding your: **Skin:** (Please check any that apply and explain)

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 spot/liver spot/brown spot	❑	Other _____	

Eyes:
dehydrated ❑ wrinkles ❑ puffiness ❑ dark circles ❑ Other: _____

Lips:
dehydrated ❑ cracked/chapped lips ❑ Other: _____

13) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)
If yes, please explain: _____

Cosmetics	❑	AHAs	❑
Medicine	❑	Fragrance	❑
Food	❑	Shellfish	❑
Animals	❑	Latex	❑
Sunscreens	❑	Drugs	❑
Iodine	❑	Other _____	
Pollen	❑		

Continued ⇨

14) What SPF do you use on your face? _____ How often/when? _____

15) What SPF do you use on your body? _____ How often/when? _____

16) Have you had any recent tanning bed or sun exposure that changed the color of your skin? ❍ No ❍ Yes

specify: _____

17) Have you experienced Botox, Restylane or Collagen injections? ❍ No ❍ Yes

specify: _____

Female Clients Only:

18) Are you taking oral contraceptives? ❍ No ❍ Yes

specify: _____

19) Any recent changes to or from your contraceptive treatment? ❍ No ❍ Yes

If so, what and when: _____

20) Are you pregnant or trying to become pregnant? ❍ No ❍ Yes

21) Are you lactating? ❍ No ❍ Yes

22) Any menopause problems? ❍ No ❍ Yes

specify: _____

23) Are you undergoing any hormone replacement therapy? ❍ No ❍ Yes

specify: _____

Male Clients Only:

24) What is your current shaving system? Wet shave ❑ Electric ❑

25) Do you experience irritation from shaving? ❍ No ❍ Yes Ingrown hairs? ❍ No ❍ Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

_____

_____

Future Appointments/Contact:

May I call you at your home, work or cell phone number to confirm future appointments? ❍ No ❍ Yes

May I contact you via mail/email about future promotions and news? ❍ No ❍ Yes

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: _____

Confidential Client Health History Form

Date: _____

Name: _____ Date Of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?
❍ No ❍ Yes, explain: _____

2) Any recent surgery, including plastic surgery? ❍ No ❍ Yes, explain: _____

_____

3) Any skin cancer? ❍ No ❍ Yes, explain: _____

4) Have you had any piercings, tattoos, or permanent cosmetics? ❍ No ❍ Yes, If yes, where on your person?

_____

_____

5) Have you ever had a body spa treatment before? ❍ No ❍ Yes, when: _____

6) Have you had any of these health conditions in the past or present?
(Please check all that apply and provide additional information in the space provided)

Cancer	❑	Headaches (chronic)	❑
Hormone imbalance	❑	Hepatitis	❑
Systemic disease	❑	Herpes	❑
High blood pressure	❑	Frequent cold sores	❑
Spinal injury	❑	Immune disorders	❑
Thyroid condition	❑	HIV/AIDS	❑
Hysterectomy	❑	Lupus	❑
Diabetes	❑	Metal bone pins or plates	❑
Heart problem	❑	Phlebitis, blood clots, poor circulation	❑
Varicose veins	❑	Blood clotting abnormalities	❑
Arthritis	❑	Psychological treatment	❑
Asthma	❑	Insomnia	❑
Eczema	❑	Keloid scarring	❑
Epilepsy	❑	Skin disease/skin lesions	❑
Seizure disorder	❑	Any active infection	❑
Fever blisters	❑		

7) Has your physician discussed concerns about raising your body temperature? ❍ No ❍ Yes

explain: _____

_____

Continued ⇨

8) Do you smoke? ❍ No ❍ Yes

9) Do you follow a restricted diet? ❍ No ❍ Yes, specify: _____

10) Do you follow a regular exercise program? ❍ No ❍ Yes

11) What is your stress level? High ❑ Medium ❑ Low ❑

List any medications you take regularly: _____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:
_____

12) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? ❍ No ❍ Yes, describe: _____

13) Have you used any of these products in the last 3 months? ❍ No ❍ Yes

14) Have you used an acne medication? ❍ No ❍ Yes, when? _____ Which drug? _____

15) Do you form thick or raised scars from cuts or burns? ❍ No ❍ Yes

16) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❍ No ❍ Yes, describe: _____

List your daily consumption of: Water _____ Caffeine _____ Alcohol _____

17) Do you experience any problems sleeping? ❍ No ❍ Yes

18) How many hours do you typically sleep each night? _____

19) Do you wear contact lenses? ❍ No ❍ Yes

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

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

22) Do you have any metal implants or wear a pacemaker? ❍ No ❍ Yes

23) Have you ever experienced claustrophobia? ❍ No ❍ Yes

24) Do you suffer from sinus problems? ❍ No ❍ Yes

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

Rash Irritation Peeling Sun Sensitivity Breakout

26) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics Medicine Food Animals Sunscreens Iodine Pollen AHAs

Fragrance Shellfish Latex Drugs Other: _____

Continued ⇨

If yes, please explain: _____

Female Clients Only:

27) Are you taking oral contraceptives? ❍ No ❍ Yes, specify: _____

28) Any recent changes to or from your contraceptive treatment? ❍ No ❍ Yes, If so, what and when? _____

_____

_____

29) Are you pregnant or trying to become pregnant? ❍ No ❍ Yes

30) Are you lactating? ❍ No ❍ Yes

31) Any menopause problems? ❍ No ❍ Yes, specify: _____

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

_____

_____

_____

_____

_____

_____

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:_____

SKIN CARE HISTORY QUESTIONNAIRE

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin-care needs.

Date ____/____/____

Name *(please print clearly)*

Date of Birth

____/____/____

First Last M.I.

Street Address

City **State** **Zip Code**

Home Phone **E-Mail Address**

( )

Please check if presently using any of the following. *(please ✓ all that apply)*

❑ Accutane ❑ Glycolic Acid/Alpha Hydroxy Acid ❑ Topical Vitamin C
❑ Hydroquinone ❑ Retinoid (Vitamin A derivatives) i.e. Retin A, Renova, Differin

Which conditions do you want to improve *(please ✓ all that apply)*

❑ Hyperpigmentation (Brown Spots) ❑ Acne/Acne Scarring ❑ Sun Damage ❑ Enlarged Pores
❑ Fine Lines & Wrinkles ❑ Age Spots ❑ Surgical Facial Scars ❑ Other: _____

Have you ever had an allergic reaction to any skin product or cosmetic? ❑ Yes ❑ No

FEMALE CLIENTS

Are you on hormone-replacement therapy? ❑ Yes ❑ No
Are you presently taking birth control pills? ❑ Yes ❑ No
Are you pregnant or planning to be? ❑ Yes ❑ No

ALL CLIENTS

Do you use a sunscreen/sunblock? ❑ Yes ❑ No
Do you sunbathe or participate in outdoor activities? ❑ Yes ❑ No

Do you have or have you ever had acne? ❑ Yes ❑ No
Are you using or have you ever used any medications for acne? ❑ Yes ❑ No
Name of medication _____

Have you seen a dermatologist in the past year? ❑ Yes ❑ No
If yes, list doctor's name and reason for visit _____

Are you presently under a doctor's care? ❑ Yes ❑ No
What medications do you take on a regular basis? _____

Have you ever had herpes (cold sores)? ❑ Yes ❑ No
Have you ever been treated with Zovirax or any medication for herpes? ❑ Yes ❑ No

SKIN CARE HISTORY QUESTIONNAIRE

Do you have epilepsy or diabetes? ❑ Yes ❑ No
If yes, you will be treated only with a doctor's release!

Do you use Biore, Snore Strips, or any other Medical Apparatuses? ❑ Yes ❑ No

Have you had any of the following? ❑ Yes ❑ No *(please ✓ all that apply)*
❑ Cosmetic Surgery ❑ Botox Injections ❑ Skin Cancer ❑ Dermatitis ❑ Keloid Scarring
❑ Laser Resurfacing ❑ Chemical Peels ❑ Hepatitis ❑ Other (Specify) _____

Are you allergic to aspirin? ❑ Yes ❑ No Are you allergic to iodine or seaweed? ❑ Yes ❑ No
Do you have any other allergies? ❑ Yes ❑ No
If yes, list: _____

Do you smoke?	❑ Yes	❑ No
Do you take nutritional supplements?	❑ Yes	❑ No
Are you on a diet?	❑ Yes	❑ No
Do you exercise?	❑ Yes	❑ No
Do you wear contact lenses?	❑ Yes	❑ No
Have you had skin treatments (facials) before?	❑ Yes	❑ No
Are you currently having facials?	❑ Yes	❑ No
Have you had electrolysis or waxing in the past week?	❑ Yes	❑ No
Do you have those services done regularly?	❑ Yes	❑ No
Have you had permanent cosmetics?	❑ Yes	❑ No

If yes, where? _____

How is your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

What skin-care products are you currently using? _____
_____

What is it about your skin you would like to change? _____
_____

Is there any other information I should know before beginning your treatment? _____
_____

Client Signature

SKIN REJUVENATION
INFORMED CONSENT

Please read and initial after each paragraph.
You have the right to be informed about your skin peeling treatment.

INITIAL HERE

I have been given the Skin History Questionnaire and have read and answered the questions thoroughly. I have discussed any further questions that I may have with my skin care specialist. _____

I am aware and acknowledge that there is a rare possibility of an allergic reaction. I have discussed thoroughly with my skin care specialist any such reactions and understand them. I have had a patch test and it is negative. _____

I am willing to forego a patch test, but understand there could be an allergic response. _____

I have been advised that my treatment is a noninvasive, light epidermal exfoliation consisting of any of the following: salicylic acid, AHAs, retinol, TCA, resorcinol, or red wine vinegar acid. _____

These are superficial procedures. The use of the above ingredients stimulates the skin to generate new skin cells and new collagen formation and increases the blood circulation and flow to the skin. It does not replace deep chemical peels, laser resurfacing or plastic surgery. _____

I acknowledge that during application I will notice a warm sensation and the skin may tingle, sting or burn. Immediately after the peel my face may appear frosted or sunburned, and by day two, the skin may darken in color, feel tighter, and be more sensitive. Days two through seven, the skin will peel. I am not to pick or peel the old skin. Pulling or picking skin may lead to infection (which will require treatment with topical antibiotic) or surface scarring. I may experience some breaking out after a peel. _____

I acknowledge that I will avoid direct sun exposure and tanning beds during this procedure and will apply a sunscreen daily. _____

Skin peels may lighten hyperpigmented skin, and I acknowledge that there is NO GUARANTEE that dark discoloration of the skin known as melasma will be reduced or faded. I am aware that there could even be an increase of uneven color from this procedure. _____

I acknowledge that I have not been on Accutane during the past six months. _____

I acknowledge that I have not been using Retin A or Renova for the past two weeks. _____

I acknowledge that if I am prone to cold sores (herpes), I may need a prescription from my physician prior to having the peel. I am aware the treatment could bring about cold sores. _____

I acknowledge that I am not aspirin-sensitive or, if I am, I have discussed this with my skin care specialist and understand that there could be a reaction. _____

I acknowledge that I will not have any other skin care procedures of any sort until I am passed by my skin care specialist to do so. _____

Client Signature	Print Name	Date
_____	_____	___/___/___

Rescheduling Policy

We appreciate your business. So that we can best serve all our clients, please be advised of these policies.

ARRIVAL TIME

Please aim to arrive 10 minutes before your scheduled appointment time. If you arrive after your scheduled appointment time, it may not be possible to extend the time available for your booked service; if your service is shortened due to your late arrival, you may still be charged the full cost of the service.

CHANGING YOUR APPOINTMENT

24 hours' notice is required to reschedule or cancel a booked appointment, except in cases of contagious illness as described below.

SICKNESS OR FAMILY EMERGENCY

If you, or another person in your household, has an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date. There is no penalty or timeframe required in this case, for your safety and that of other clients.

I agree to the policies described above.

Client Name _____

Client Signature _____ Date_____

Client Consent Form

I hereby consent to and authorize _____ to perform the following procedure:
(esthetician)

_____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by _____.
(esthetician)

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed) _____

Client Name (signature) _____ Date_____

Esthetician _____ Date_____