Client Consultation

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

Employer: _____ Occupation: _____

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) Do you have eyelash extensions? ❍No ❍Yes

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	Black Complexion	Never 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, Deferin, Glycolic Acid, AHA, Salicylic 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) 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

10) 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: _____

11) 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	❑	Aspirin	❑
Pollen	❑		

Other _____

12) Have you experienced claustrophobia? ❍No ❍Yes

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 experienced Botox, Restylane or Collagen injections? ❍ No ❍ Yes

specify:_____

Female Clients Only:

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

specify:_____

19) 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

Health History:

24) Have you been under a physicians, dermatologist, or other medical professional within the past year?

❍No ❍Yes, explain:_____

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

26) Do you smoke? ❍No ❍Yes

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

Diabetes	❑	Keloid Scarring	❑
Eczema	❑	High Blood Pressure	❑
Frequent Cold Sores	❑	Epilepsy	❑
Skin disease/skin lesion	❑	Hepatitis	❑
HIV/AIDS	❑		

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

_____

_____

_____

Future Appointments/Contact:

May I text/call you at your home 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:_____