Skin Consultation Form

Name: _____ **Date of Birth:** _____

Address: _____

Email: _____

Home phone: _____ **Cell phone:** _____

Would you like to receive text notifications/confirmations? (Circle One) Yes No

Referred by: _____

Emergency Contact Name and Phone Number:

_____

Would you like to be notified by email of spa specials, events and promotions? Yes No

Main reason for today's visit: _____

_____

Healthy History and Skin Care

Within the last year, have you been under a dermatologist's or other physician's care?

(Circle One) No Yes

Please list any injuries, surgeries or health conditions:

_____

Please Check All Conditions That Apply:

[ ] Allergy – Latex	[ ] Blood Thinners	[ ] Epilepsy/Seizures	[ ] Oral Steroids
[ ] Allergy – Shellfish	[ ] Body Piercings	[ ] Heart Disease	[ ] Pacemaker
[ ] Allergy – Aspirin	[ ] Cancer	[ ] Heart Murmur	[ ] Radiation/Chemo
[ ] Allergy – Fragrances	[ ] Cold sores	[ ] Hepatitis B/C	[ ] Smoking
[ ] Artificial Joints	[ ] Contact Lense	[ ] HIV/AIDS	[ ] Thyroid Disease
[ ] Autoimmune Disease	[ ] Diabetes	[ ] Metal Implants	

Please list any other allergies or medications:

_____

_____

Do you use sun block? [ ] Yes [ ] No **SPF:** _____

Do you sunbathe, use self-tanners or go tanning? [ ] Yes [ ] No

Does your job require that you work outdoors? [ ] Yes [ ] No

What types of activities do you like to do for fun? _____

Have you ever had a facial treatment before? [ ] No [ ] Yes

If Yes, when were you seen last _____ For _____

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

What areas of concern do you have regarding your Skin: (Please check all that apply)

[ ] Breakouts/Acne
[ ] Redness/Ruddiness
[ ] Blackheads/Whiteheads
[ ] Excessive Oil/Shine
[ ] Rosacea
[ ] Broken capillaries
[ ] Peeling
[ ] Uneven skin tone
[ ] Sun damage
[ ] Wrinkles/fine lines
[ ] Dull/dry skin
[ ] Flaky skin
[ ] Dehydrated
[ ] Tightness
[ ] Rough Texture
[ ] Other_____

What are your skin care goals? _____

Do you use any of the following:

[ ] Retin-A [ ] Renova [ ] Adapalene Hydroxyl Acid [ ] Retinol

[ ] Accutane [ ] Differin [ ] Tazorac [ ] Trentinoin

If any of the following have been used, please indicate when _____

What skin care products are you currently using? (please circle)

Soap Cleanser Moisturizer Mask Toner Exfoliator Eye Products Scrubs SPF

Shower Gel Night Cream Serum Makeup Remover Acne Treatment

Prescription Products (please list): _____

Have you ever had chemical peels, laser or microdermabrasion? No Yes

If Yes, when? _____ Type of Treatment? _____

Female Clients Only:

Are you taking oral contraceptives? [ ] No [ ] Yes

Are you pregnant or trying to become pregnant? [ ] No [ ]Yes

Are you lactating? [ ] No [ ] Yes

Waxing Information

Have you ever had any adverse reactions to waxing? [ ] Yes [ ] No

If yes, please explain: _____

When did you last shave? _____ **How often do you shave?** _____

Do you have any tendencies to any of the following (circle all that apply)

Ingrown Hair Hyperpigmentation Bumps/Hives Bruising Scarring

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. For future services, I agree to inform my spa technician of any changes in my medical status and/or the above information.

I understand spa services are not to be considered medical treatment, and as such, the spa technician cannot prescribe treatment of pharmaceuticals.The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Cancellation policy: In order to provide optimal scheduling for all clients and to fairly compensate out therapist, the company finds it necessary to implement a 24-hour cancellation policy for all spa appointments.

Client Name (Please Print): _____

Signature: _____ Date:_____

FOR PARENTS/GUARDIANS OF PARTICIPANT OF MINOR AGE (UNDER AGE 18)

This is to certify that I, as a parent/guardian with legal responsibility for this participant, do consent and agree to his/her release of services to be completed by the skincare practitioner.

Parent/Guardian of Minor: _____

Date: _____ Emergency Phone: _____