



ELEVENTH ELEMENT
RELAXATION SPA

Facial Client Consultation Form

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Sex: Female Male

How were you referred to us? _____

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

YOUR SKIN CARE

1. Have you ever had a facial treatment before? No Yes
2. SKIN TYPE: Review the skin types below. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):
 - 1) Very fair skin; blonde or red hair; light-colored eyes; freckles common o ll. Fair skinned; light hair, light eyes
 - 2) Very common skin type; fair; eye and hair color vary
 - 3) Mediterranean Caucasian skin; medium to heavy pigmentation
 - 4) Mideastern skin; rarely sun sensitive
 - 5) Black skin; rarely sun sensitive

3. Do you have any special skin problems or concerns pertaining to your face? No Yes
If yes, please specify: _____

4. Have you ever had chemicals peels, laser treatments, or microdermabrasion in the last month? No Yes

5. Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products?
 No Yes If yes, please specify what and when last used: _____

6. Do you have any of the following conditions:
 Epilepsy Eczema Dermatitis Hormone imbalance Pregnancy and/or breastfeeding
 Autoimmune disease Herpes Simplex Diabetes

7. Do you have any other health condition not mentioned here? Yes ___ No ___ If yes, please list _____

8. Have you experienced Botox, Restylane, or collagen injections/filler? No Yes
If yes, please specify: _____

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

Cleanser _____	Toner _____
Day Moisturizer _____	Night Moisturizer _____
Exfoliator _____	Mask _____
Eye Product _____	SPF/Sunscreen _____



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Client Consultation Form—Continued

10. Have you used any hair removal methods in the past six weeks? No Yes (Check all that apply)
 Shaving Waxing other: _____

11. 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: _____

11) Have you recently used any self-tanning lotions, creams, or treatments? 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 certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures. 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): _____

Client/Guardian Name (Signature): _____

Date: _____