Facial Treatment

FACIAL CONSULTATION FORM

PERSONAL INFORMATION

Name:_____ Date:_____

Date of birth:_____ ☐ Female ☐ Male ☐ NB

Address:_____

City:_____ Postal Code:_____ Phone:_____

Emergency Contact:_____ Phone:_____

How did you hear about us?

_____

Would you like to be added to our email list for news, sales or exclusive offers? ☐ Yes ☐ No

MEDICAL HISTORY

Do you have or have you had any of the follow conditions? If yes, please select those that apply

☐ Acne	☐ Headaches	☐ Parkinson's type symptoms
☐ Anxiety	☐ Hepatitis	☐ Phlebitis, blood clots
☐ Arthritis /Joints	☐ High blood pressure	☐ Reproductive
☐ Asthma	☐ HIV/AIDS	☐ Seizure disorder
☐ Blood disorder	☐ Hyper pigmentation	☐ Seborrhea
☐ Cancer	☐ Hypo pigmentation	☐ Skin disease/lesions
☐ Chronic Fatigue	☐ Hysterectomy	☐ Stress
☐ Diabetes	☐ Immune disorders	☐ Sleepnessness / Oversleeping
☐ Eczema	☐ Insomnia	☐ Stomach / Bowels
☐ Epilepsy	☐ Keloid scarring	☐ Thyroid condition
☐ Fever blisters	☐ Low blood pressure	☐ Tonsils/ Adenoids / Throat
☐ Fibromyalgia	☐ Lupus	☐ Varicose veins
☐ Heart condition	☐ Liver / Spleen	☐ Warts
☐ Herpes	☐ Metal bone pins/plates	☐ _____

Any other conditions not listed above we should be aware of: _____

_____

Any known allergies? _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

_____

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____

♀ Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

What is your activity level: ☐ Very Active ☐ Active enough ☐ Sedentary

How's your water intake on average? ☐ Uhhhh, not great ☐ Could be better ☐ I love water

Do you have a daily routine? ☐ Not really ☐ I try ☐ Yes, I do

Are you at home or working outside the home?_____

What hobbies do you enjoy?

_____

What are you currently doing regularly to contribute to good health? (Exercise, Naturopath, Osteo, Massage, Chiro, Reiki, Reflexology, other) _____

_____

Are you currently seeing someone for any medical conditions? _____

SKIN HISTORY

Have you ever had a facial treatment before? ☐ No ☐ Yes

If yes, please explain _____

_____

What did you enjoy or dislike about your experience _____

_____

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

_____

In your opinion,

What is your skin type? ☐ Normal ☐ Oily ☐ Dry ☐ Combo ☐ Unsure

Your exposure to the sun? ☐ Never ☐ Light ☐ Moderate ☐ Lots o' sun

What type of foundation do you wear? ☐ Liquid ☐ Cream ☐ Powder ☐ None

How does your skin heal? ☐ Fast ☐ Slow ☐ Scars ☐ Pigmentation

Do you get bruises easily? ☐ No ☐ Yes

Do you have a sensitive scalp? ☐ Yes ☐ No, please play with my hair

Do you currently have a skin routine? ☐ Yes ☐ Kinda ☐ No

Please check current products you use:

☐ Eye Make up remover	☐ Eye Cream	☐ Mask
☐ Creamy cleanser	☐ Day Cream	☐ Facial Scrub
☐ Facial soap	☐ Night Cream	☐ Exfoliants
☐ Skin toner/ Astringent	☐ Neck lotion	☐ Body Lotion
☐ Body soap	☐ Hand cream	☐ Body scrub

Have you ever used acne medication? ☐ No ☐ Yes

If yes, when? _____ Which drug? _____

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? ☐ No ☐ Yes, please describe: _____

_____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

☐ No ☐ Yes, please specify: _____

_____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the practitioner of any changes in the above information. I understand that my pracitioner is NOT a medical doctor and cannot diagnose, prescribe or treat for any specific physical or mental condition. I agree to waive all liabilities toward my practitioner and their operating business for any injury or damages incurred due to any misrepresentation of my health history.

I consent to receive treatment.

Client name (print) : _____

Client name (signature): _____ Date: _____