Spa Haven

Client Name: _____ Birthday: _____
last first month/day

Client Address: _____ apt/unit _____

City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

How did you hear about us? _____ Have you had a facial before? _____

YOUR HEALTH (fill in and/or circle answer)

1. Within the last year, have you been under a dermatologist or other physician's care? Yes No
2. Have you had any health problems in the past or present that I should be aware of? Yes No
3. List any medications, vitamins, etc. that you take regularly: _____
   _____
4. Do you smoke? Yes No
5. Do you wear contact lenses? Yes No
6. Do you have any metal implants, a pacemaker or body piercings? Yes No
7. Do you have any allergies? If yes, please specify: _____ Yes No
8. Do you sunbathe or use tanning beds? Yes No
9. Are you claustrophobic? Yes No

YOUR SKIN (fill in and/or circle answer)

10. What are your specific concerns/challenges with your skin?_____
11. What is one thing you would change about your skin? _____
12. What skin care products are you currently using?
    Soap Cleanser Toner Moisturizer Masque Exfoliator Eye Products Serums
    Glycolic Acid Lactic Acid Vitamin A derivatives (Retinol)
13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? Yes No
14. Do you ever experience these conditions on your skin? Flakiness Tightness Obvious Dryness
15. What SPF do you wear on your face? _____
16. Do you burn easily in moderate sunlight? Yes No
17. Do you have a tendency to redness? Yes No
18. Do you suffer from sinus problems? Yes No
19. Do you ever experience burning, itching or stinging sensations on your skin? Yes No

Female Clients ONLY- are you pregnant? Taking oral contraceptive? Are you lactating? Yes No

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature: _____ Date: _____