FACIAL TREATMENT CONSENT FORM

Date: _____ Name: _____ D.O.B: _____

Health Related:

☐ Yes ☐ No - Are you pregnant?
☐ Yes ☐ No - Are you planning to become pregnant?
☐ Yes ☐ No - Are you Nursing?
☐ Yes ☐ No - Do you have any metal implants/pins/plates or medical implants? (Including dental, and full body)
• If Yes, where is it located and what type of implant is it? _____
☐ Yes ☐ No - Do you smoke cigarettes regularly?
☐ Yes ☐ No - Do you use a vape or e-pen? (Nicotine or Marijuana)
☐ Yes ☐ No - Do you participate in vigorous aerobic activities or sports? How often: _____X a Week
☐ Yes ☐ No - Have you had: ☐ Cold Sores ☐ Herpes ☐ Hives ☐ Keloids outbreak in the past 30 days?
• If Yes, when and where was your last outbreak: _____
☐ Yes ☐ No - Do you wear Contact Lenses? (Please remove contacts prior to treatment if eyes are sensitive.)
☐ Yes ☐ No - Do you wear sunscreen (SPF) on a regular basis?
☐ Yes ☐ No - Have you visited a tanning booth within the last week (If Yes, your service **may** have to be rescheduled.)
☐ Yes ☐ No - Have you received a spray tan within the last week? If Yes, When: _____
☐ Yes ☐ No - Have you been sunburned in the past two weeks?
☐ Yes ☐ No - Are you currently taking any antibiotics? (May increase sensitivity.)

Skin Care Related:

☐ Yes ☐ No - Are you currently using products containing Glycolic Acid or Alpha Hydroxy Acids?
• If Yes, how long have you been using the products and how has your skin reacted to it? _____

_____

☐ Yes ☐ No - Are you currently using Accutane? (Acne Medication) If Yes, How long?_____
☐ Yes ☐ No - Have you ever used Hydroquinone? (Skin Lightner) If Yes, How long ago? _____
☐ Yes ☐ No - Do you currently use wax, electrolysis, or depilatories on your face?
• If Yes, when and what was your last treatment? _____

Have you **ever** had any of the following:	→	→	→ Within the last 30 days?
Microdermabrasion ☐ Yes ☐ No	When: _____		☐ Yes
Chemical Peel ☐ Yes ☐ No	When: _____		☐ Yes
Laser Resurfacing ☐ Yes ☐ No	When: _____		☐ Yes
Collagen or Botox ☐ Yes ☐ No	When: _____		☐ Yes
Facial Surgery ☐ Yes ☐ No	When: _____		☐ Yes
Permanent Make Up ☐ Yes ☐ No	When: _____		☐ Yes

To help us determine a facial regimen suitable for you, please describe your skin-type: (Check all that apply)

☐ Thick ☐ Thin ☐ Saggy ☐ Firm ☐ Sensitive ☐ Resilient ☐ Normal

☐ Dry ☐ Rosacea ☐ Eczema ☐ Oily ☐ Acne ☐ Prone to breakouts

☐ Combination ☐ Large Pores ☐ Small Pores ☐ Freckled ☐ Sun Damaged ☐ Acne Scarred ☐ Unevenness

☐ Melasma ☐ Psoriasis ☐ Wrinkled ☐ Mature ☐ Broken Capillaries ☐ Milia

☐ Congested ☐ T-Zone Congestion ☐ Hyper-Pigmentation ☐ Hypo-Pigmentation

What is your skin-tone: (Check all that apply)

☐ Pale/White ☐ Light ☐ Medium ☐ Reddish ☐ Freckled ☐ Olive

☐ Light Brown ☐ Med. Brown ☐ Dark Brown ☐ Black ☐ Other: _____

What is your natural eye color:

☐ Blue ☐ Green ☐ Hazel ☐ Grey ☐ Light Brown ☐ Med. Brown ☐ Dark Brown

What is your natural hair color: (not the color it is currently dyed)

☐ White ☐ Black ☐ Blond ☐ Red ☐ Grey/Silver ☐ Salt & Pepper

☐ Light Brown ☐ Med. Brown ☐ Dark Brown ☐ Other: _____ (Natural colors only please)

Questionnaire:

What improvements would you like to see in your skin? _____

_____

What type of facial treatment did you last have? _____

What did you enjoy most about the treatment? _____

What did you least like about the treatment? _____

CONSENT AGREEMENT

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Studio Skyn, LLC. updated as to any changes in my medical profile and understand that there shall be no liability of the service provider should I fail to do so. My questions regarding the treatment have been answered satisfactorily.

I understand the treatment and accept any risks. I hereby release Studio Skyn, LLC and its staff from all liabilities associated with the above indicated treatment. I agree that this consent supersedes any previous verbal or written disclosures.

This consent is valid for all of my facial treatments in the future as well.

_____	_____	_____
Signature of Client (Or Guardian)	Print Name (Relation if necessary)	Date
_____	Ryan DuPree FB9771808	_____
Signature of Esthetician	Print Name	Date