

# FACIAL TREATMENT CONSULTATION

CORE BEAUTY

## PERSONAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

Would you like to be added to our email list for news and exclusive offers?  Yes

## HEALTH HISTORY

Please check any of the following conditions that apply to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne            | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Low blood pressure     |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Hepatitis A/B/C     | <input type="checkbox"/> Lupus                  |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Metal bone pins/plates |
| <input type="checkbox"/> Blood disorder  | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Spinal Injury          |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hyper pigmentation  | <input type="checkbox"/> Seizure disorder       |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hormone Imbalance   | <input type="checkbox"/> Skin Disease Disorder  |
| <input type="checkbox"/> Eczema          | <input type="checkbox"/> Hysterectomy        | <input type="checkbox"/> Seborrhea              |
| <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Immune disorders    | <input type="checkbox"/> Thyroid condition      |
| <input type="checkbox"/> Fever blisters  | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Veins/Phlebitis        |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Keloid scarring     | <input type="checkbox"/> Warts                  |

Any other conditions: \_\_\_\_\_

Do you have any medication allergies?  No  Yes \_\_\_\_\_

Are you currently taking any medication (including vitamins and supplements)? List it here:  
\_\_\_\_\_

Any surgeries in the last six months?  No  Yes \_\_\_\_\_

Are you pregnant or breastfeeding?  No  Yes \_\_\_\_\_

## SKIN INFORMATION

1) What are your skincare goals?

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2) What skin problems do you think you have?

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3) What is your skin type?  Normal  Oily  Dry  Combination  Not sure

4) Your exposure to the sun?  Light  Moderate  Excessive

5) Do you wear SPF?  No  Yes

6) How does your skin heal?  Fast  Slow  Scars  Bruises

7) Do you use acne medication?  No  Yes (specify) \_\_\_\_\_

8) Have you had facials before?  No  Yes (specify) \_\_\_\_\_

9) Have you ever had chemical peel, laser, microdermabrasion, or any skin resurfacing treatments?  No  Yes (specify)

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

No  Yes (specify)

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11) Have you used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products in the last 6 months?  No  Yes (specify)

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12) Check current products you use:

Eye Make-Up Remover

Eye Cream

Mask

Cleansing Cream

Day Cream

Facial Scrub

Facial Soap

Night Cream

Exfoliants

Skin Toner/ Astringent

Neck Lotion

Body Lotion

Body Soap

Hand Cream

Body Scrub

Any other information you'd like to provide:

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# FACIAL TREATMENT

## CONSULTATION

I understand that:

- If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort.
- I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment.
- I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.
- I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session.

By signing below, I agree to the following:

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle. I understand that there is the possibility I may require further treatments of the treated areas at an additional cost in order to obtain the expected results.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my health history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

CLIENT NAME (PRINTED)

CLIENT SIGNATURE

DATE

ESTHETICIAN