

Refreshing Springs Day Spa Client Consultation Form



NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Sex: Female Male

How were you referred to us? _____

Occupation: _____ Does your job require that you work outdoors? No Yes

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

YOUR SKIN CARE

1) Have you ever had a facial treatment before? No Yes, when? _____

2) Have you ever had a body spa treatment before? No Yes

If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

- | | | |
|--------------------------|----------|--|
| <input type="checkbox"/> | Type I | Fair skin tones—Always burns, never tans |
| <input type="checkbox"/> | Type II | Light skin tones—Burns easily, tans slightly |
| <input type="checkbox"/> | Type III | Fair to olive skin tones—Burns moderately, tans moderately |
| <input type="checkbox"/> | Type IV | Light brown skin tones—Burns slightly, tans easily |
| <input type="checkbox"/> | Type V | Dark brown skin tones—Rarely burns, tans easily |
| <input type="checkbox"/> | Type VI | Dark brown to black skin tones—Never burns, tans easily |

4) Do you have any special skin problems or concerns pertaining to your face or body? No Yes

If yes, please specify: _____

5) Have you ever had chemicals peels, laser treatments, or microdermabrasion? No Yes

In the last month? No Yes

6) 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: _____

7) Have you used acne medication? No Yes, when? _____ Which medication? _____

8) Have you experienced Botox, Restylane, or collagen injections? No Yes

If yes, please specify: _____

Refreshing Springs Day Spa Client Consultation Form —Continued



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 _____
 Scrubs _____ Makeup Products _____
 Soap _____ Shower Gels _____
 Body Lotions _____ Other _____

10) Have you used any hair removal methods in the past six weeks? No Yes (Check all that apply)

Shaving Waxing Electrolysis Plucking Tweezing
 Stringing Depilatories 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: _____

Eyes (Check all that apply)

Dehydrated Wrinkles Puffiness
 Dark circles Other: _____

Lips (Check all the apply)

Dehydrated Cracked/chapped lips Other: _____

12) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____
 Cosmetics AHAs Medication
 Fragrance Food Shellfish
 Animals Latex Sunscreens
 Drugs Iodine Pollen
 Other: _____

13) What SPF do you use on your face? _____ How often/when? _____

14) Have you recently used any self-tanning lotions, creams or treatments? No Yes

If yes, please specify: _____

15) Have you had any recent tanning bed or sun exposure that changed the color of your skin? No Yes

If yes, please specify: _____



LIFESTYLE

- 16) How many glasses of water do you drink per day? (Please check one)
 <1 glass 1-3 glasses 4-7 glasses 8+ glasses
- 17) How many caffeinated beverages (coffee, tea, soda, etc.) do you consume per day? (Please check one)
 None 1-2 drinks 3-5 drinks 6+ drinks
- 18) How many alcoholic beverages do you consume per week? (Please check one)
 I don't drink 1-3 drinks 4-7 drinks 8+ drinks
- 19) How many hours of sleep do you get per night? (Please check one)
 <3 hours 3-5 hours 6-8 hours 8-10 hours 10+ hours
- 20) Which foods do you consume on a regular basis?
 Fruits Vegetables Dairy/Eggs Cheese Poultry
 Fish Grains/Bread Processed Sugar Processed Meats
- 21) What does your daily commute look like?
 Car Bike Public Transport Walk I don't commute
- 22) How often do you travel on a plane?
 Never 1-2 times per year 1-2 times per quarter Every month Every week
- 23) How many hours do you spend in front of a screen or digital device?
 <3 hours 4-6 hours 7-9 hours 10-12 hours 12+ hours
- 24) Do you exercise on a regular basis? No Yes
- 25) Do you smoke cigarettes, vape, or consume other tobacco products? No Yes
- 26) What are your stress levels on a scale from 1 to 5 (1 = low stress, 5 = high stress)? _____

FEMALE CLIENTS

- 27) Are you taking oral contraceptives? No Yes
 If yes, please specify: _____
- 28) Any recent changes to or from your contraceptive treatments? No Yes
 If yes, please specify what and when: _____
- 29) Are you pregnant or trying to become pregnant? No Yes
- 30) Are you experiencing any menopausal symptoms? No Yes
 If yes, please specify: _____
- 31) Are you undergoing any hormone replacement therapy treatments? No Yes
 If yes, please specify: _____

MALE CLIENTS

- 32) Do you experience irritation from shaving? No Yes
 If yes, please specify: _____
- 33) Do you experience ingrown hairs as a result of hair removal? No Yes



FUTURE APPOINTMENTS/CONTACT

May I call you at the provided phone number to confirm future appointments? No Yes

May I contact you via mail/email about future promotions and news? 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 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 Name (Signature): _____ Date: _____