Facial Client Information Form

Name:_____Date:_____Therapist Name:_____

Street Address:_____City:_____State:_____

Zip:_____ Telephone ( )_____ Cellular: ( )_____

E-mail: _____Occupation:_____

Date of Birth:_____under 21_____21-30_____31-40_____41-50_____Over 50____

Reason for visit?_____How did you hear about us?_____

Emergency Contact Name:_____Emergency Contact Number_____

CLIENT HISTORY

Have you had any of these health problems
In the past or present?

___Cancer ____Hormone Imbalance
___Diabetes ____Hysterectomy
___Epilepsy ____Thyroid
___Heart Problem____Varicose Veins
___Claustrophobia

Do you smoke? _____yes ____no
Had chemical peels? _____yes ____no
Use Retin-A? _____yes ____no
Used the Acne drug, Accutane?____yes____no
Have regular sleep patterns _____yes____no
Wear contact lenses? _____yes____no
Have metal implants or pacemaker?___yes__no

Do you have any special skin problems Pertaining to your face?

_____yes _____no

(Check All That Apply)

_____Pores _____Redness

_____Acne _____Pigmentation

CAPILLARY ACTIVITY

Do you burn easily in moderate sunlight?
_____yes _____no

Do you blush easily when nervous?
_____yes _____no

Do you have a tendency to redness?
_____yes _____no

What type of massage pressure do you prefer?
_____yes _____no

Have you ever had a reaction to any of the following?

_____cosmetics _____pollen
_____medicine _____food
_____iodine _____AHA's
_____animals _____fragrance
_____sunscreens _____other-list:

_____

FEMALE CLIENTS ONLY

Are you pregnant or trying to become pregnant?
_____yes _____no

_____Wrinkles/Aging _____Scarring

_____Dryness _____Hair

Other_____

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**

Client Profile Notes

1._____

_____

Product Recommended/Sold:

_____

_____

Aesthetician:_____Date_____

2._____

_____

Product Recommended/Sold:

_____

_____

Aesthetician:_____Date:_____

3._____

_____

Product Recommended/Sold:

_____

_____

Aesthetician:_____Date:_____

4._____

_____

Product Recommended/Sold:

_____

Aesthetician:_____Date:_____