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)

☐	Type I	Fair skin tones—Always burns, never tans
☐	Type II	Light skin tones—Burns easily, tans slightly
☐	Type III	Fair to olive skin tones—Burns moderately, tans moderately
☐	Type IV	Light brown skin tones—Burns slightly, tans easily
☐	Type V	Dark brown skin tones—Rarely burns, tans easily
☐	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: _____

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: _____