



Consent for Facial Treatment

Client Name: _____

Date of Birth: _____

Contact Number: _____

Email Address: _____

The goal of a Facial treatment as in any cosmetic procedure, is improvement, not perfection. I understand that my results may not be perfect. In the case of a facial treatment, the number of treatments necessary will vary among individuals and the areas being treated.

I understand that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected results.

Is this your first facial treatment? Yes No

Is there any specific area(s) that concern you? _____

Are you presently under a physician's care for any skin condition or other problem? _____

Are you pregnant or think you may be pregnant? Yes No

Are you taking birth control? Yes No If yes, what type? _____

Are you taking hormone replacement medication? _____

Do you wear contact lenses? Yes No

Do you often experience stress? Yes No

Have you been diagnosed with skin cancer? Yes No If yes, what type? _____

Are you currently using or have you used in the past any of the listed medications? Circle all that apply.
Azelex Differin Renova Retin-A Tazarac Glycolic or Alphahydroxy Acids

How long did you use the medication circled above? _____

Do you have any allergies? Yes No If yes, what type? _____

Are you currently taking any medications? Yes No

If yes, what type and for how long? _____

Have you ever used Accutane? Yes No

Do you have acne? Yes No If yes, for how long? _____

Do you experience frequent blemishes? Yes No If yes, for how long? _____

Which of these products are you currently using on your face? Circle all that apply.

Soap Cleansing Milk Toner Scrub Mask Cream Sunscreen Other _____

How much plain water do you consume daily? _____

Have you ever experienced any of the following conditions with your skin? Circle all that apply.

Flakiness Tightness Obvious Dryness

Do you ever experience oily shine during the day? Yes No

Occasionally Are you currently having or will soon have your menstrual period? Yes No

Have you started any new medication? Yes No If yes, what type? _____

Is all the information on your health history form up to date? _____

If no, please complete a new Health History Form

I understand that I may have some discomfort, redness and swelling for 2 hours to 7 days, itching or irritation, skin peeling or flaking for up to 7 days after the procedure and I could have possible scarring as a result.

It is my decision to have this treatment and I certify that I have read and have full understanding of the above consent.

I have been given ample opportunity for discussion and all of my questions have been answered to my satisfaction.

I hereby consent to the facial treatment procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. Elle Med Spa LLC is not responsible for any injury or allergic reaction(s) or any skin abrasions as a result of the services performed on me.

Name (Printed): _____

Signature: _____

Date: _____

Technician: _____

Date: _____