Beauty by Victoria J, LLC **CLIENT INFORMATION FORM** DATE: _____

If you previously filled out this form: Any changes since last visit? ▢ **No** ▢ **Yes** (*If yes, please indicate changes on form)*

Name: _____ **Gender** ▢ M ▢ F **Age** _____ **DOB** _____
Address: _____ **City** _____ **State** _____ **Zip** _____
Preferred Contact Number _____ **Email** _____
May I leave a message if I do not reach you personally? ▢ Yes ▢ No

Esthetician Notes:

What are your top 3 concerns at this time?
1. _____
2. _____
3. _____

Medical History

Pregnant? ▢ Yes ▢ No ▢ Maybe ▢ N/A Breastfeeding? ▢ Yes ▢ No ▢ N/A
Do you smoke? ▢ Yes ▢ No
Health Conditions: _____
Past Surgeries: _____
Have you ever been diagnosed with Cancer? ▢ No ▢ Yes *(last treatment date)*_____
Current Medications: _____
Prescription Topicals: _____
Allergies (include aspirin & iodine): _____

Previous Treatments:

Facials	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
Microdermabrasion	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
Chemical Peels	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
Osmosis Revita-Pen	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
LED Light Therapy	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
Dermaplane	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
Waxing	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____
Laser Therapy	▢ Yes ▢ No	Last Treatment: _____	Any Complications?_____

Skin Conditions: *(please indicate the items below that pertain to you)*

Skin Infection	▢	Herpes (cold sores)	▢	Keloids/Excessive Scarring	▢	Sun Sensitivity	▢
Skin Cancer	▢	Poor Healing	▢	Microblade/Perm. Makeup	▢	Easy Bruising	▢
Eczema	▢	Psoriasis	▢	Lymph Nodes Removed	▢	Diabetes	▢

Skincare: What type of skin do you feel you have? ▢ Dry ▢ Oily ▢ Normal ▢ Combination
What is your skin routine? *(indicate any cleansers, toners, serums, moisturizers, etc.)*
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____
CLIENT SIGNATURE PRINT NAME DATE