PURE Radiance DAY SPA

FACIAL CONSULTATION FORM

ALL INFORMATION IS CONFIDENTIAL

Today's Date: __________

Name:____ Birthday:________________

Address:____

City:______________________________ State:_________________ Zip code:__________________

Home Phone #:_______________Work Phone #: _______________Occupation:_________________________

Cell Phone #:___________________________ Email:____

Marital Status:_____Male: ____Female :____Emergency Contact:________________________ #: ____________

MEDICAL HISTORY

Check Box Where Applicable/Fill In With Details:

( ) Accutane
( ) Arthritis
( ) Epilepsy
( ) Fever Blisters
( ) HIV
( ) Lupus
( ) Plastic Surgery
( ) Psoriasis
( ) Vitamins
( ) Rashes
( ) Warts

( ) Acne
( ) Depression
( ) Diabetic
( ) Eczema
( ) Hepatitis
( ) Insomnia
( ) Pregnant
( ) Retin-A
( ) Seborrhea
( ) Shingles
( )Other: ____

( ) Allergies:______________________________________
( ) Any Metals in Body
( ) Heart Condition ( ) Pacemaker
( ) Blood Pressure ( ) high ( ) low
( ) Hyper/Hypo Pigmentation
( ) Hyper/Hypo Thyroid
( ) Medications: ___________________________________
( ) Planning on getting Pregnant
( ) Skin Cancer
( ) Surgeries:______________________________________

PERSONAL SKIN CARE HISTORY

Check Current Products you use:

( ) Eye Make-Up Remover
( ) Day Cream
( ) Mask
( ) Body Lotion/Cream

( ) Cleansing Cream
( ) Night Cream
( ) Facial Scrub
( ) Body Scrub

( ) Facial Soap
( ) Eye Cream
( ) Exfoliants
( ) Hand Cream

( ) Sunscreen
( ) Skin Toner / Astingent
( ) Neck Cream
( ) Body Soap

PERSONAL EVALUATION QUESTIONNAIRE

Please Reply In Detail To the Following Questions:

1. How did you hear about us?

____

2. What is your major reason for being here today?

____

____

(Continued)

3. What skin type and/or problem do you feel you have?

____

____

4. Have you ever had a facial treatment before? If yes, where and when? Was it a beneficial experience?

____

____

5. Have you ever had a reaction to a food, cosmetic, or skin care product? If yes, please give details:

____

____

6. Where do you purchase most of your face and body care products?

____

7. How much time do you spend on your daily skin care/make-up routine?

____

8. How you feel about your skin conditions? What would you like to improve?

____

____

9. Do you tend to tan or burn? _______________________

10. Do you smoke or drink? How often? _______________________

11. Do you exercise and how often? _______________________

12. How much sleep do you get per night? _______________________

13. Are you interested in long or short term spa treatment? _______________________

14. Are you pleased with your current products: _______________________

15. Have you ever been waxed? _______________________

I understand and agree to comply with all the salon and spa policies listed below:

1. We do not wax anyone on Accutane, Retin-A, Epiduo, or other medications/products that exfoliate or thin the skin. We do not wax anyone undergoing chemotherapy or radiation treatments.
2. We will not treat clients with questionable medical conditions such as Herpes Simplex (cold sores, fever blisters), open wounds or sores, healing incisions, infectious diseases, etc. We do not massage clients undergoing cancer, diabetes, or systemic treatments or any other specific contra-indications for the body.
3. **We require a minimum of 24 hours advance cancellation notice.** Any client giving less will be charged up to 100% of the service price.
4. I understand that services received here are not a substitute for MEDICAL CARE and any information provided by the technician is for educational purposes only.
5. All information received by the client on this chart, is completely private and confidential.
6. We do not give cash refunds.
7. Defective products must be returned within ten (10) days of purchase to receive credit.
8. Gift Certificates are non-refundable.
9. **ALL SALES ARE FINAL**

_______________________ _______________________

NAME **DATE**

PURE Radiance DAY SPA

FACIAL CONSENT FORM

Please read and initial next to each statement acknowledging you understand and agree to each statement.

________ I am over 18 years of age, or I have parental consent co-signed below.

________ I understand that my facial treatment may include clinical-strength products, enzymes, acid peels, dermabrasion, dermaplaning, extractions, microcurrent, galvanic, high frequency, ultrasonic, LED Light Therapy and other treatment modalities as necessary.

________I understand that this is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximal results, I may need more than one treatment and I need to follow the maintenance home protocol.

________I understand that there are no guarantees as to the result of this treatment, due to many variables such as age, conditions of the skin, sun damage, smoking and climate. I may or may not experience actual "peeling" with this procedure as each case is individual.

________I understand that there may be some degree of discomfort, i.e. stinging, "pin-pricking" sensation, hotness or tightness.

________I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact my Service Provider.

________ I agree to refrain from tanning or excessive sun exposure while I am undergoing treatment and 14 days after my treatment. I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sun block protection with a minimum SPF 30 is mandatory.

________ I will reveal any medical conditions that may effect the treatment such as pregnancy, cold sore tendencies, allergies, recent facial peels, laser or surgery, any types of contraindicated medications such as Accutane, hormone replacement therapy, steroidal medications or use of Retin-A. Contraindicated medications should be discontinued five days prior to the treatment with exception of Accutane which must be discontinued for six months prior.

________I have not had a peel treatment of any kind within 14 days of my treatment, from my Service Provider or any other Service Providers. I understand I cannot have another treatment until recommended by my Service Provider. I understand my responsibility of properly fulfilling the appropriate after care instructions as explained by my Service Provider

________PHOTOGRAPHS: I give permission for photographs to be used by my Service Provider and his/her staff staff for monitoring my treatment progress.

________Prior to receiving treatment, I have been candid in revealing any condition that may have an effect on this procedure as outlined. I will also inform my Service Provider of any changes in my medical history, current medications and/or any changes relevant to this procedure prior to any future treatments.

________I have read the contents of this consent form carefully and I fully understand it. I have been given the opportunity for discussion pertaining to the treatment and all my questions have been answered to my satisfaction. I hereby release my Service Provider, whose signature is below, and any of his/her staff against any and all liability associated with this procedure. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the treatment.

________With my signature below, I give consent to receive treatments to my Service Provider and have read and completed this questionnaire truthfully. I understand I will be receiving a professional service from a licensed Service Provider. I further understand that the Service Provider neither diagnoses illness, disease or any other medical, physical, or mental disorder. I am responsible for consulting a qualified physician for any ailment that I have. Because the Service Provider must be aware of any existing physical conditions that I have, I have listed all my known medical conditions and physical limitations and I will inform the specialist in writing of any change in my physical health. I agree that this constitutes full disclosure. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. If any information changes between my appointments, I will let my Service Provider know. I understand that there shall be no liability on the Service Provider for any services rendered.

Client Name (printed):____

Client Signature:____ Date:_______________

Parent/Guardian Name (printed):____

Parent/Guardian Signature:____ Date:_______________

Esthetician:____ Date:_______________