SKINCARE

Client Consultation Form

Client's Information

Full Name: _____

How did you hear about us? _____ DOB: _____ ☐ Female ☐ Male ☐ NB

Address: _____ City: _____ ZIP Code: _____

E-mail: _____ Phone: _____

Skin concerns & goals

What brings you in today? Anything for me to target or treat?

_____

_____

Skin History

Please check any of the following that apply to you:

- ☐ Dry
- ☐ Oily
- ☐ Combination
- ☐ Discoloration
- ☐ Acne Scarring
- ☐ Uneven Texture
- ☐ Fine Lines & Wrinkles
- ☐ Enlarged Pores
- ☐ Sun Damage
- ☐ Rosacea
- ☐ Acne/Breakouts
- ☐ Dark Under-Eye Circles
- ☐ Other: _____

Emergency Contact

Full Name: _____

Phone: _____ Relationship: _____

Medical Information

Please check any of the following that apply to you:

- ☐ Headaches/Migraines
- ☐ Neuropathy/Numbness
- ☐ Allergies
- ☐ Diabetes
- ☐ High/low blood pressure
- ☐ Blood Clots
- ☐ Autoimmune diseases
- ☐ Surgeries/Joint Replacement
- ☐ Cancer
- ☐ Rosacea
- ☐ Epilepsy or seizures
- ☐ Asthma
- ☐ Allergies to Specific Ingredients or Products: _____
- ☐ Recent Facial Surgeries or Treatments: _____
- ☐ Other Medical Concerns: _____

Skin Care History

Morning	Evening
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Have you ever, or are you currently receiving skin treatments? If yes, please tell us about your treatments:

_____

when was your last treatment? _____

Consent and Agreement

I understand that the facial treatment is not a substitute for medical treatment or advice. I have provided accurate information to the best of my knowledge & agree to inform the technician if any of the above information changes. I consent to the facial treatment and agree to follow the technician's recommendations for aftercare and skincare.

Client's Signature: _____ Technician's Signature: _____

Date: _____ Date: _____