Beauty Seasons Salon

Client Information

Full Name: _____

Date of Birth: _____

Phone: _____

Email: _____

Emergency Contact (Name & Phone): _____

Medical History (Check all that apply)

- Active acne
- Rosacea
- Eczema / Dermatitis
- Psoriasis
- Cold sores (HSV-1)
- Recent chemical peel (last 4 weeks)
- Recent laser treatment (last 4 weeks)
- Autoimmune disorder
- Diabetes
- Thyroid disorder
- Cancer (current or past)
- Heart condition
- High blood pressure
- Recent surgery (last 6 months)
- Recent facial fillers (last 4 weeks)
- Recent Botox (last 2 weeks)
- Pregnancy or Breastfeeding
- None

Please list any medications or supplements:

_____

_____

Allergies & Sensitivities

Fragrance / Essential Oils / Nuts / Latex / Metals / Skincare Ingredients / Other

_____

Contraindication Acknowledgment

I understand that treatments may be modified or postponed if contraindications are present, including active infections, open wounds, recent injectables, illness, or uncontrolled medical conditions.

Initials: _____

Informed Consent

I understand that facial treatments, including manual sculpting, lymphatic techniques, and buccal massage, involve manipulation of facial and neck tissues. Possible temporary side effects may include mild redness, tenderness, temporary breakouts, or slight swelling. Results vary and no guarantees have been made.

I voluntarily consent to receive treatment and release Beauty Seasons Salon from liability except in cases of gross negligence.

Signature: _____

Date: _____

Professional Conduct Policy

Beauty Seasons Salon maintains a safe and respectful environment. Inappropriate behavior, harassment, or violation of professional boundaries will result in immediate termination of services without refund.

Initials: _____

Photo Consent (Optional)

■ I consent to photos for internal records.

■ I consent to anonymous use for educational/marketing purposes.

■ I do not consent to photography.

Signature: _____