

**Facial Intake, Consultation & Waiver**

Name: Date:

Phone Number: Email:

Birthday: Address:

Please List any Medications or Herbal Supplements you are currently using, as these could affect your skin and may be contraindicative to the treatment:

Allergies or Sensitivities:

Botox / Fillers / Laser / Chemical Peels / Permanent Makeup within the last month (or planned for within the next 30 days): Y / N If so, please state date:

Have you ever received professional facial skincare treatments in the past? Y / N If so, please state date of and type of last treatment:

Have you ever had an adverse reaction to any skincare treatment? Y / N If so, please state date and cause and reaction:

Have you been in the sun or tanning in the last 24 hours? Y / N

Are you planning on being in the sun and or tanning in the next 72 hours? Y / N

Have you been under direction or care of a Dermatologist in the past year? Y / N

Have you taken Accutane, Retin A or Adapalene Hydroxyl Acid (all typically used for Acne treatment) within the last 3 months? Y / N

Have you used Over The Counter (OTC) Benzoyl Peroxide or OTC Salicylic Acid, AHA / Glycolic Acid in the last 7 days? Y / N

Are you pregnant? Y / N

Do you have Asthma? Y / N

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**Have you had any of these health conditions in the past or present? (Please check all that apply and provide additional information in the space provided)** Cancer Arthritis Immune disorders HIV Eczema Lupus High blood pressure Epilepsy Metal pins / plates Phlebitis/blood clots Thyroid condition Headaches (chronic) Fever blisters Diabetes Hepatitis Heart problem Herpes/ Frequent cold sores Skin disease/skin lesions

**Which of the following do you feel best describes your skin type?** Very oily / large pores Oily Dry Combination Sensitive

**Please circle what you feel your skin concerns or conditions are affecting you that you would like to focus on during this facial treatment:**  Pigmentation Acne Fine Lines Discoloration Brown spots Rosacea Wrinkles Loss of skin tone Broken capillaries/veins Dryness Large pores Sun Damage Acne Blackheads Thinning skin Balance Hydration Collagen Detox

**What is your current homecare routine and product brands:** Cleanser Toner Exfoliant Mask Serum Moisturizer Hydration SPF Dermaroller Other Brands:

**How often do you go for facial treatments (circle)**  1 - 2 x year 3-4 x year 6x+ Never

**Aesthetician Use**

Aesthetician Comments and Recommendations:

* Skin type, skin conditions, products, regime & routine, additions, further treatments, avoidances, lifestyle and course of action recommended.

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**Release Waiver**

I, , understand and have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. I understand there is a chance that an adverse reaction could occur, such as hives or rash, mild burn and will contact the service provider to discuss further course of action. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof. I understand that the therapist or esthetician does not diagnose illnesses or prescribe medications, though may suggest alterations. I understand that it is my responsibility to inform my therapist or esthetician of any discomfort I may feel during the session so she may adjust accordingly. I have been advised of what to expect during and post treatment. I have been given a chance to ask questions about the session and my questions have been answered.

Name:

Signature:

Date:

Aesthetician: Signature:

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