ELEVENTH ELEMENT

RELAXATION SPA

Facial Client Consultation Form

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ZIP_____

PHONE _____ EMAIL_____

Sex: ▫ Female ▫ Male

How were you referred to us? _____

What would you like to achieve from your treatment today?_____

YOUR SKIN CARE

1. Have you ever had a facial treatment before? ❍No ❍Yes
2. SKIN TYPE: Review the skin types below. This information will be used by your technician to determine the most appropriate way to approach your treatment(s):
    1) Very fair skin; blonde or red hair; light-colored eyes; freckles common o II. Fair skinned; light hair, light eyes
    2) Very common skin type; fair; eye and hair color vary
    3) Mediterranean Caucasian skin; medium to heavy pigmentation
    4) Mideastern skin; rarely sun sensitive
    5) Black skin; rarely sun sensitive

3. Do you have any special skin problems or concerns pertaining to your face? ❍No ❍Yes
If yes, please specify: _____

4. Have you ever had chemicals peels, laser treatments, or microdermabrasion in the last month? ❍No ❍Yes

5. Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products?
❍No ❍Yes If yes, please specify what and when last used:_____

6. Do you have any of the following conditions:
___ Epilepsy ____Eczema ____Dermatitis ___Hormone imbalance ____Pregnancy and/or breastfeeding
____Autoimmune disease ____Herpes Simplex ____Diabetes

7. Have you experienced Botox, Restylane, or collagen injections/filler? ❍No ❍Yes
If yes, please specify: _____

8. What skin care products are you currently using? (List brands if known)
Cleanser _____ Toner _____
Day Moisturizer _____ Night Moisturizer _____
Exfoliator _____ Mask _____
Eye Product _____ SPF/Sunscreen _____

Client Consultation Form—Continued on back

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9. Have you used any hair removal methods in the past six weeks? ❍No ❍Yes (Check all that apply)
□ Shaving □ Waxing other:_____

11. What areas of concern do you have regarding your skin (Check all that apply)

□ Breakouts/acne	□ Uneven skin tone	□ Blackheads/whiteheads
□ Sun damage	□ Excessive oil/shine	□ Wrinkles/fine lines
□ Rosacea	□ Dull/dry skin	□ Broken capillaries
□ Flaky skin	□ Redness/ruddiness	□ Dehydrated
□ Sun/liver/brown spots	□ Other: _____	

10. Have you recently used any self-tanning lotions, creams, or treatments? ❍No ❍Yes

11. Do you have any allergies? ❍No ❍Yes

If yes, please specify: _____

_____

12. Do you have any other health condition not mentioned here? ❍No ❍Yes

If yes, please specify _____

_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to execute appropriate treatment procedures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Emergency Contact: _____ Phone: _____

Client Name (Printed): _____

Client or Guardian Name (Signature): _____

Date: _____