FACIAL CLIENT CONSULTATION FORM

– PERSONAL & CONFIDENTIAL –

Name: _____ **Gender:** _____ **Date:** _____

Address: _____ **City:** _____ **ZIP/Postal:** _____

Phone #: _____ **Age:** _____ **Occupation:** _____

Esthetician: _____ **Referred By:** _____

Do you have any allergies to food, cosmetics, or drugs? ☐ Yes ☐ No

If yes, please list: _____

Do you have any of the following:

☐ Sunburn ☐ Moles ☐ Eczema ☐ Phlebitis ☐ Psoriasis ☐ High Blood Pressure

☐ Asthma ☐ Diabetes ☐ Skin Cancer ☐ HIV ☐ Hepatitis ☐ Heart Problems

☐ Epilepsy ☐ Lupus ☐ Hemophilia ☐ Other: _____

Are you pregnant? ☐ Yes ☐ No **On birth control / hormone replacement?** ☐ Yes ☐ No

Are you taking any medications? ☐ Yes ☐ No ***If yes, please list:*** _____

Are you under the care of a skin care therapist, physician, or dermatologist? ☐ Yes ☐ No

Are you or have you been using or taking any of the following? ☐ Acne Medication

☐ Vitamin A Therapies **Products Containing:** ☐ Hydroquinone ☐ Alpha Hydroxyl

Have you had any of the following procedures?

☐ Laser Resurfacing ☐ Chemical Peel ☐ Botox or Collagen Injections

☐ Other: _____ ***Date of Last Treatment:*** _____

Have you had a facial before? ☐ Yes ☐ No ***Date of Last Facial:*** _____

Do you have any areas of concern? _____

How does you skin react to the sun? _____

Do you experience frequent blemishes? How frequently? _____

Have you ever experienced burning, itching, redness, or irritation? _____

What products do you currently use? ☐ Soap ☐ Cleanser ☐ Toner ☐ Exfoliate or Scrub

☐ Mask ☐ Moisturizer ☐ Sunscreen ***What brand name?*** _____

Client Signature _____