



Client Consultation Document

Name: _____ DOB: ___/___/___

Address _____

Phone _____ Email _____

Occupation: _____

Emergency Contact _____

What type of skin do you have?

Normal Oily Dry Sensitive Reactive

What areas of concern do you have regarding your skin?

Uneven Skin Tone Blackheads/Whiteheads Aging Redness Breakouts/Acne
 Broken Capillaries

Other: _____

Have you been under the care of a doctor within the past year? Yes No

If yes, please explain:

Do you take any medications? If so, please list:

Have you ever had an allergic reaction to any of the following?

Facial AHAs Cosmetics Medicine Food Animals Sunscreen Drugs Iodine
 Pollen Fragrance Shellfish Latex Other:

Do you currently or have you used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products in the last 3 months? Yes No

If yes, please

describe: _____

Are you currently using any beauty devices in your daily regimen?

Clarisonic Brush My Skin Buddy NuFace LightStim Other:

Is SPF part of your daily routine?

Yes No



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What is your current level of stress?

Normal Low High

What is your current weather climate?

Humid Dry Depends on the day

Checking for Contraindications

Is there anything I should know about you, your health, or history that has not been discussed? Please explain:

If you could wave a magic wand how would your skin look and feel after our virtual facial? Please explain:

Anything else you want to share? I love learning about my clients as it helps me provide superior customer service.