

# FACIAL TREATMENT

## Client Consultation Form

### Client's Information

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male  NB

Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Does your job require you to work outdoors:  Yes  No

How did you hear about us? \_\_\_\_\_

### Skin Concerns & Goals

What would you like to achieve from your treatment today?

Have you ever had a facial treatment before?  Yes  No Specify below: \_\_\_\_\_

Have you ever had chemical peels, laser treatments or micordermabrasion?  Yes  No Specify below: \_\_\_\_\_

Do you use Accutane, Retin-A, Adapalene Hydroxyl Acid or any other Retinol/Vitamin A derivative products?

Yes  No Specify: \_\_\_\_\_ Last used: \_\_\_\_\_

Have you used Acne medication?  Yes  No Specify: \_\_\_\_\_ Last used: \_\_\_\_\_

Have you experienced Botox, Resylane or collagen injections?  Yes  No Specify below: \_\_\_\_\_

Have you ever, or are you currently receiving skin treatments? If yes, please tell us about your treatments: \_\_\_\_\_

**Skin History** Please check any of the following that apply to you:

- |                                     |   |   |  |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> Dry        | <input type="checkbox"/> Oily           | <input type="checkbox"/> Combination            | <input type="checkbox"/> Acne Scarring         |
| <input type="checkbox"/> Rosacea    | <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Acne/Breakouts         | <input type="checkbox"/> Uneven Texture        |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Discoloration  | <input type="checkbox"/> Dark Under-Eye Circles | <input type="checkbox"/> Fine Lines & Wrinkles |

## Skin History

Which of the following best describes your skin type? (Please check one)

- Type I Fair skin tones: always burns, never tans
- Type II Light skin tones: burns easily, tans slightly
- Type III Fair to Olive skin tones: Burns moderately, tans moderately
- Type IV Light Brown skin tones: Burns slightly, tans easily
- Type V Dark Brown skin tones: Rarely burns, tans easily
- Type VI Dark Brown to Black skin tones: Never burns, tans easily

Do you have any special skin problems or concerns pertaining to your face or body?

Yes  No Specify: \_\_\_\_\_

## Health History

1. Oral Contraceptives:  Yes  No Specify: \_\_\_\_\_
2. Recent changes w/ contraceptives:  Yes  No Specify: \_\_\_\_\_
3. Menopausal symptoms:  N/A  Yes  No Specify: \_\_\_\_\_
4. Hormone treatment:  Yes  No Specify: \_\_\_\_\_

Have you ever, or are you currently receiving skin treatments? If yes, please tell us about your treatments:

When was your last treatment? \_\_\_\_\_

## Medical Information

Please check any of the following that apply to you:

- |  |   |   |                                    |
|--|---|---|------------------------------------|
| <input type="checkbox"/> Pregnant/Trying     | <input type="checkbox"/> Nursing              | <input type="checkbox"/> Skin Allergies | <input type="checkbox"/> Rx: _____ |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Rx: _____ |
| <input type="checkbox"/> Autoimmune diseases | <input type="checkbox"/> Implants             | <input type="checkbox"/> Sun Damage     | <input type="checkbox"/> Rx: _____ |
| <input type="checkbox"/> Rosacea             | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Asthma         |                                    |
- Allergies to Specific Ingredients or Products: \_\_\_\_\_
- Recent Facial Surgeries or Treatments: \_\_\_\_\_
- Other Medical Concerns: \_\_\_\_\_

## Emergency Contact

Full Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Lifestyle

Please check any of the following that apply to you: **PER DAY/NIGHT**

- Water intake:  1-2 8oz glass  3-4 8oz glass  5-6 8oz glass  7-8 8oz glass  8+ 8oz glass
- Caffeine intake:  None  1-2 drinks  3-5 drinks  6+ drinks
- Alcohol intake:  Do not drink  1-3 drinks  4-7 drinks  8+ drinks
- Sleep Hygiene:  <4 hrs  5-7 hrs  8-10 hrs  11+ hrs
- Foods consume regularly:  Fish/Seafood  Poultry  Beef  Dairy/Eggs  Cheese  
 Fruits  Grains/Breads  Processed Sugars/Refined  Processed Meats  Fast Foods
- Daily Commute:  Car  Bike  Public Transport  Walk  Do not commute
- Flight Travel:  1-2x/year  1-2x/month  Every month  Every week  Never
- Screen Time:  <3 hrs  4-6 hrs  7-9 hrs  10-12 hrs  12+ hrs
- Exercise regularly:  Yes  No
- Smoke products: Cigarettes, Vape, other Tabacco, Other:  Yes  No
- Stress Levels: Scale 1-5 (1 = Low, 5 = High): \_\_\_\_\_
- Do you wear SPF daily?  Yes  No What type SPF? \_\_\_\_\_

## Skin Care Current Home Regime

Morning	Evening
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

## Consent and Agreement

**I understand that the facial treatment is not a substitute for medical treatment or advice. I have provided accurate information to the best of my knowledge. I consent to the facial treatment and agree to follow the technician's recommendations for aftercare and skincare.**

Client's Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_

Esthetician's Signature:

\_\_\_\_\_

Date:

\_\_\_\_\_



# FACIAL TREATMENT

Client Consultation Form

**Esthetician Notes:** (please include initial & date with every entry)