



Facial Treatment

CONSULTATION FORM

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fungal Condition | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Keloid Scarring |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Herpes | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Metal Bone Pins/ Plates |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis, Blood Clots |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Easily Bruised/Sensitive Skin | <input type="checkbox"/> Hyper Pigmentation | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hypo Pigmentation | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fever Blister | <input type="checkbox"/> Immune Disorders | _____ |

Any known allergies? ☐ No ☐ Yes _____

List any medications you take regularly including vitamins, herbal supplements, aspirin:

Any recent surgery, including plastic surgery? ☐ No ☐ Yes _____

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

Do you smoke or consume alcohol? ☐ No ☐ Yes

FACIAL TREATMENT CONSULTATION FORM PT 2

SKIN CARE

Please mark any of the following products you may be currently using

- | | | | |
|--|--------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Eye Make-up Remover | <input type="checkbox"/> Body Soap | <input type="checkbox"/> Neck Lotion | <input type="checkbox"/> Exfoliants |
| <input type="checkbox"/> Cleansing Cream | <input type="checkbox"/> Eye Cream | <input type="checkbox"/> Hand Cream | <input type="checkbox"/> Body Lotion |
| <input type="checkbox"/> Facial Soap | <input type="checkbox"/> Day Cream | <input type="checkbox"/> Mask | <input type="checkbox"/> Body Scrub |
| <input type="checkbox"/> Skin Toner | <input type="checkbox"/> Night Cream | <input type="checkbox"/> Facial Scrub | <input type="checkbox"/> Other |

SKIN HISTORY

Please mark any of the following conditions you may currently have.

- | | | | | |
|-----------------------------|---------------------------------|--------------------------------|--------------------------------------|------------------------------------|
| Skin Type: | <input type="checkbox"/> Normal | <input type="checkbox"/> Oily | <input type="checkbox"/> Combination | <input type="checkbox"/> Unsure |
| Sun Exposure: | <input type="checkbox"/> Never | <input type="checkbox"/> Light | <input type="checkbox"/> Moderate | <input type="checkbox"/> Excessive |
| Foundation: | <input type="checkbox"/> Liquid | <input type="checkbox"/> Cream | <input type="checkbox"/> Powder | <input type="checkbox"/> None |
| How does your skin heal?: | <input type="checkbox"/> Slow | <input type="checkbox"/> Fast | <input type="checkbox"/> Scars | <input type="checkbox"/> Pigment |
| Do you get bruises easily?: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |

SKIN CONCERNS

Please mark any of the following conditions you may currently have.

- | | | | |
|---|---|--------------------------------------|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fine Lines/ Wrinkles | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Blackheads | <input type="checkbox"/> Hyperpigmentation | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thin Skin |
| <input type="checkbox"/> Broken Capillaries | <input type="checkbox"/> Hypopigmentation | <input type="checkbox"/> Redness | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Dryness/ Dull Skin | <input type="checkbox"/> Keloids | <input type="checkbox"/> Scarring | <input type="checkbox"/> Other |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Milla | <input type="checkbox"/> Sensitivity | _____ |

Have you ever had facial treatment before? ☐ No ☐ Yes _____

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

Have you used any acne medication? ☐ No ☐ Yes

If yes, when: _____ Which drug: _____

Have you used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products in the last 3 months?

☐ No ☐ Yes, please explain: _____

Have you used received Botox, Restylane, or Collagen injection in the last six months?

☐ No ☐ Yes, please explain: _____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any falsification of my medical history

Client Name (Printed)

Client Name (signature)