Images
SALON & SPA

Facial Treatment

CONSULTATION FORM

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male

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.

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

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

- Eye Make-up Remover
- Facial Cleanser
- Exfoliant
- Toner
- Serum
- Sunscreen
- Night Cream
- Mask

SKIN HISTORY

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

Skin Type:	Normal	Oily	Dry	Combination
Sun Exposure:	Never	Light	Moderate	Excessive
How does your skin heal?:	Slow	Fast		
Do you get bruises easily?:	Yes	No		

SKIN CONCERNS

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

- Acne
- Blackheads
- Broken Capillaries
- Dryness/ Dull Skin
- Eczema
- Fine Lines/ Wrinkles
- Hyperpigmentation
- Hypopigmentation
- Keloids
- Milla
- Oily Skin
- Psoriasis
- Redness
- Scarring
- Sensitivity
- Sun Damage
- Thin Skin
- Unwanted Hair
- Other _____

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: _____

<u>By signing below, you agree to the following:</u>

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)