

ESTHETIC SERVICES

Client Consultation Form

Name: _____

Address: _____

Email Address: _____

Birthdate: Month _____ Day _____

Anniversary: Month _____ Day _____

What skin care concern(s) do you have pertaining your face or body? _____

Therapist: _____

Tel#: _____

Other Tel#: _____

Emergency Tel#: _____

How did you hear about us? _____

Check ALL that apply:

- | | |
|---|--|
| <input type="checkbox"/> Ingrown Hairs | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Taking Oral Contraceptive |
| <input type="checkbox"/> Hormone Imbalance | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Use SPF 15 or Higher |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Contact Lens User |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Any Metal Implants | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Hypoglycemic | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Caffeine: Daily __ Wkly __ | <input type="checkbox"/> Tobacco User |

Undergone Dermatology Treatment
(List All) _____

Surgery in last 12 months
(List All) _____

List ALL medication(s) you are currently taking: _____

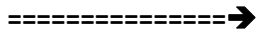
Currently using other topical medication
(List All) _____

- Currently taking Isotretinoin (Accutane)
 Currently taking Retinols (Vitamin A Derivative)
 Currently using topical AHA/BHA?

Select one (1) that matches your skin type:

Skin Type	Characteristics
<input type="checkbox"/> 1	Always burns Never tans
<input type="checkbox"/> 2	Usually burns Tans less than average
<input type="checkbox"/> 3	Sometimes mild burns Tans more than average
<input type="checkbox"/> 4	Rarely burns Tans more than average
<input type="checkbox"/> 5	Rarely burns Tans profusely
<input type="checkbox"/> 6	Never burns Deeply pigmented

- Sun Sensitive
 Allergic to:
 Aspirin Salicylic Acid Salt/Sea Salt
 Food & other allergies
(List All) _____



Check ALL that apply:

What facial skin care products are you currently using?

- | | |
|---|---|
| <input type="checkbox"/> Soap | <input type="checkbox"/> Cleanser |
| <input type="checkbox"/> Toner/Astringent | <input type="checkbox"/> Masque |
| <input type="checkbox"/> Moisturizer | <input type="checkbox"/> Exfoliator/Acid/Scrub |
| <input type="checkbox"/> Topical Vitami | <input type="checkbox"/> Topical Serum |
| <input type="checkbox"/> Eye Product | <input type="checkbox"/> Other Product(s) _____ |

Any allergic reaction(s) to the above products? Yes No

List reaction(s): _____

Do you experience an oily shine during the day? Yes No Occasionally

Do you experience skin breakouts? Yes No Occasionally

How many ounces of plain water do you consume daily? _____

How many alcoholic beverages do you consume weekly? _____

Do you ever experience these conditions on your skin Flakiness Tightness Obvious Dryness

What SPF sunscreen do you use on your face? _____

What SPF sunscreen do you use on your body? _____

Are you currently sunbathing and/or using a tanning bed? Yes No

FEMALE Clients Only

Are you taking oral contraception? Yes No

Are you pregnant or trying to become pregnant? Yes No

Are you lactating? Yes No

MALE Clients Only

What is your current shaving system? Electric Shave Wet Shave

Do you experience irritation from shaving? Yes No

Do you experience ingrown hairs? Yes No

I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health status.

Signature: _____ Date: _____