

Client Consultation



Date: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail address: _____

Single: No Yes Married: No Yes If yes, anniversary date: _____

Employer: _____ Occupation: _____

Does your job require that you work outdoors? No Yes

Referred by: _____

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

Your Skin Care

1) Have you ever had a facial treatment before? No Yes, when? _____

2) Have you ever had a body spa treatment before? No Yes, when? _____

Massage: No Yes

Salt glow: No Yes

Seaweed wrap: No Yes

Moor mud: No Yes

Body scrub: No Yes

Other: _____

3) Which of the following best describes your skin type? (Please circle one type number)

I	Creamy complexion	Always burns easily, never tans
II	Light Complexion	Always burns, tans slightly
III	Light/Matte Complexion	Burns moderately, tans gradually
IV	Matte Complexion	Seldom burns, always tans well
V	Brown Complexion	Rarely burns, deep tan
VI	Black Complexion	Never burns, deeply pigmented

4) Do you have any special skin problems or concerns pertaining to your face or body? Yes No

specify: _____

5) Have you ever had chemical peels, laser or microdermabrasion? No Yes In the last month? No Yes

6) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? No Yes

describe: _____

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Client Consultation—continued

7) Have you used any of these products in the last 3 months? No Yes

8) Have you used an acne medication? No Yes, when? _____ Which drug? _____

Soap _____	Shower Gels _____
Toner _____	Body Lotions _____
Mask _____	Sunscreen _____
Eye Product _____	SPF _____
Cleanser _____	Night Moisturizer/Cream _____
Day Moisturizer _____	Other _____
Exfoliator _____	Makeup Products _____
Scrubs _____	_____

9) What skin care products are you currently using? (List brand where known)

10) Have you recently used any self-tanning lotions, creams or treatments? No Yes, specify: _____

11) Have you used any of the following hair removal methods in the past six weeks? No Yes, circle all that apply.

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

12) What areas of concern do you have regarding your: **Skin:** (Please check any that apply and explain)

Breakouts/acne	<input type="checkbox"/>	Uneven skin tone	<input type="checkbox"/>
Blackheads/whiteheads	<input type="checkbox"/>	Sun damage	<input type="checkbox"/>
Excessive oil/shine	<input type="checkbox"/>	Wrinkles/fine lines	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	Dull/dry skin	<input type="checkbox"/>
Broken capillaries	<input type="checkbox"/>	Flaky skin	<input type="checkbox"/>
Redness/ruddiness	<input type="checkbox"/>	Dehydrated	<input type="checkbox"/>
Sun spot/liver spot/brown spot	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

Eyes:

dehydrated wrinkles puffiness dark circles Other: _____

Lips:

dehydrated cracked/chapped lips Other: _____

13) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)

If yes, please explain: _____

Cosmetics	<input type="checkbox"/>	AHAs	<input type="checkbox"/>
Medicine	<input type="checkbox"/>	Fragrance	<input type="checkbox"/>
Food	<input type="checkbox"/>	Shellfish	<input type="checkbox"/>
Animals	<input type="checkbox"/>	Latex	<input type="checkbox"/>
Sunscreens	<input type="checkbox"/>	Drugs	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	Other _____	<input type="checkbox"/>
Pollen	<input type="checkbox"/>		

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Client Consultation—continued

14) What SPF do you use on your face? _____ How often/when? _____

15) What SPF do you use on your body? _____ How often/when? _____

16) Have you had any recent tanning bed or sun exposure that changed the color of your skin? No Yes

specify: _____

17) Have you experienced Botox, Restylane or Collagen injections? No Yes

specify: _____

Female Clients Only:

18) Are you taking oral contraceptives? No Yes

specify: _____

19) Any recent changes to or from your contraceptive treatment? No Yes

If so, what and when: _____

20) Are you pregnant or trying to become pregnant? No Yes

21) Are you lactating? No Yes

22) Any menopause problems? No Yes

specify: _____

23) Are you undergoing any hormone replacement therapy? No Yes

specify: _____

Male Clients Only:

24) What is your current shaving system? Wet shave Electric

25) Do you experience irritation from shaving? No Yes Ingrown hairs? No Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)

Future Appointments/Contact:

May I call you at your home, work or cell phone number to confirm future appointments? No Yes

May I contact you via mail/email about future promotions and news? No Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____