CLIENT INFORMATION AND CONSENT FORM – FACIAL TREATMENTS

Name: ____

Address: ____

Phone: _______________________________ Email: _______________________________________

Date of Birth: __________________________ Referred by: __________________________________

Occupation: ___________________________ Emergency Contact: ____________________________

Questionnaire:

What is your main goal for today's treatment? ____

Is this your first facial? Yes No If no, when was your last facial? _________________________

What are your primary skin concerns? ____

Are you presently under a physician's care for any current skin conditions or medical issues? Yes No

If yes, please explain: ____

Do you wear contact lenses? Yes No

Do you smoke? Yes No

Do you have any allergies to foods, drugs, or cosmetics? Yes No

If yes, please list all known allergens: ____

Do you have a history of skin cancer?

Please describe your current skin care regimen:

____

____

Have you had any of these health conditions in the past or present? (please check all that apply)

Cancer	Varicose Veins	Hepatitis
Hormone Imbalance	Arthritis	HIV/AIDS
Systemic Disease	Asthma	Immune Disorders
High Blood Pressure	Eczema	Lupus
Spinal Injury	Epilepsy	Metal bone, pins, or plates
Thyroid Condition	Seizure Disorder	Blood Clotting Abnormalities
Diabetes	Frequent Cold Sores	Insomnia
Heart Problem	Herpes	Skin Disease/Lesions

Please discuss any boxes checked above with the esthetician, prior to service and update as your medical needs change.

I understand that skincare services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid my esthetician providing the service and will be held completely confidential, adhering to HIPAA privacy laws.

Have you been exposed to the sun or used a tanning bed within the last 48 hours? Yes No

Have you ever had an adverse reaction after using skin care products? (Please circle all that apply)

Rash Irritation/Redness Peeling Sun Sensitivity Breakout

Are you pregnant? Yes No

Any menopause problems? Yes No If yes, please specify: ____

Any other comments or concerns you feel are important for the esthetician be aware of, prior to treatment?
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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. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. 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: _______________