

## Client Consultation Form

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: \_\_\_\_\_

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

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

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

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

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 _____	

**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)

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 _____	
Pollen	<input type="checkbox"/>		

If yes, please explain: \_\_\_\_\_

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

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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)

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### 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: \_\_\_\_\_