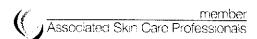
ent Consu	Itation Forn	1						
NAME		DATE of BIRTH						
ADDRESS		CITY	STATE	ZIP				
PHONE		EMAIL						
Sex: □ Fe	male 🛛	Male						
		Does your job re						
-		from your treatment today?						
		YOUR SKIN CAR	<u>E</u>					
1) Have you	ever had a facial	treatment before? O No O Yes, v	when?					
2) Have you	ever had a body	spa treatment before? O No O Ye	es					
If yes, plea	ase specify when	and what treatment:		· · · · · · · · · · · · · · · · · · ·				
3) Which of t	Which of the following best describes your skin type? (Please check one)							
	. 7	Fair skin tones—Always bur						
	_/	Light skin tones—Burns eas Fair to olive skin tones—Bur		ratoly				
		Light brown skin tones—Bur		lately				
		Dark brown skin tones—Rar						
		Dark brown to black skin ton		sily				
4) Do you ha	ve any special sl	kin problems or concerns pertainin	ng to your face or body? O	No O Yes				
If yes, plea	use specify:	* · · · · · · · · · · · · · · · · · · ·						
5) Have you	Have you ever had chemicals peels, laser treatments, or microdermabrasion? O No O Yes							
In the last	month? O No O	Yes						
6) Do you us products?	e Accutane, Reti O No O Yes	n-A, Renova, Adapalene Hydroxyl	I Acid or any other Retinol/	vitamin A derivativ				
If yes, plea	ise specify what	and when last used:		A				
7) Have you	used acne medic	ation? O No O Yes, when?	Which medicati	on?				
8) Have you e	experienced Boto	x, Restylane, or collagen injection	ns? O No O Yes					
if yes, plea	se specify:	and the state of t						



# Client Consultation Form—Continued

	Cleanser	Toner				
	Day Moisturizer	Night Moisturizer  Mask  SPF/Sunscreen  Makeup Products				
	Exfoliator					
	Eye Product					
	Scrubs					
	Soap	Shower Gels				
	Body Lotions	Other				
10)	☐ Shaving ☐ Waxing ☐ Elect	past six weeks? O No O Yes (Check all that apply) rolysis				
11)	☐ Rosacea ☐ Dull/dry sk ☐ Flaky skin ☐ Redness/ri	n tone				
	Eyes (Check all that apply) ☐ Dehydrated ☐ Wrinkles	☐ Puffiness				
	Lips (Check all the apply)	apped lips   Other:				
12)	Have you ever had an allergic reaction to any of	he following (Check all that apply)				
	If yes, please specify:  ☐ Cosmetics ☐ AHAs ☐ Fragrance ☐ Food ☐ Animals ☐ Latex ☐ Drugs ☐ Iodine ☐ Other:	☐ Medication ☐ Shellfish ☐ Sunscreens ☐ Pollen				
13)	What SPF do you use on your face?	How often/when?				
	Have you recently used any self-tanning lotions,					
15)		osure that changed the color of your skin? O No O Ye				
	If yes, please specify:	·				

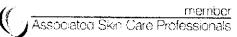


## Client Consultation—Continued



### LIFESTYLE

	How					er day? (Please che 4-7 glasses		ne) 8+ glasses		
	How	many caffeina None	ated b		ee, t □	tea, soda, etc.) do y 3-5 drinks		onsume per d 6+ drinks	ay? (F	Please check one)
	How	many alcohol I don't drink	ic bev		con	sume per week? (F 4-7 drinks	Please			
•	How	many hours o	of slee			ight? (Please check 6-8 hours		8-10 hours		10+ hours
·	Whice			sume on a reg Vegetables Grains/Bread				Cheese Processed M	□ ⁄leats	Poultry
-	Wha □	it does your da Car	aily co	mmute look lik Bike	ke? □	Public Transport		Walk		l don't commute
		often do you Never 🏻 1				1-2 times per quarte	er (	□ Every mor	nth	☐ Every week
	How	many hours o	do you	-	t of a	a screen or digital d 7-9 hours		? 10-12 hours		12+ hours
24) Do you exercise on a regular basis? O No O Yes										
25) Do you smoke cigarettes, vape, or consume other tobacco products? O No O Yes										
26) What are your stress levels on a scale from 1 to 5 (1 = low stress, 5 = high stress)?										
FEMALE CLIENTS										
27) Are you taking oral contraceptives? O No O Yes										
If yes, please specify:										
28) Any recent changes to or from your contraceptive treatments? O No O Yes										
If yes, please specify what and when:										
29) Are you pregnant or trying to become pregnant? O No O Yes										
30) Are you experiencing any menopausal symptoms? O No O Yes										
If yes, please specify:										
31) Are you undergoing any hormone replacement therapy treatments? O No O Yes										
If yes, please specify:										
MALE CLIENTS										
32) Do you experience irritation from shaving? O No O Yes										
If yes, please specify:										
33)	33) Do you experience ingrown hairs as a result of hair removal? ○ No ○ Ves									



### **Client Consultation**—Continued



### **FUTURE APPOINTMENTS/CONTACT**

May I call you at the provided phone number to confirm future appointments? O No O Yes May I contact you via mail/email about future promotions and news? O No O 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 the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Client Name (Printed):	
Client Name (Signature):	Date: