Confidential Facial Consultation Form

General Information

Name _____ Birthday _____
Address _____
City _____ State/Province _____ Zip/Postal Code _____
Phone # _____ Email_____
Occupation _____
Emergency Contact Name _____ Phone # _____
Would you like to be added to our email list for specials and discounts? ☐Yes ☐No
How did you hear about us? _____

Medical History

Please check all that apply:

☐Acne	☐Acne Scarring	☐Arthritis
☐Asthma	☐Blood Disorder	☐Bronchitis
☐Claustrophobia	☐Contact Lenses	☐Depression
☐Dermatitis	☐Diabetes	☐Digestive Problems
☐Easy Bruising	☐Eczema	☐Epilepsy
☐Fever Blisters	☐Fungus	☐Gynecological Conditions
☐Headaches/Migraines	☐Heart Condition	☐Hepatitis
☐Hernia	☐Herpes	☐High Blood Pressure
☐History of Cancer	☐History of Mental Illness	☐HIV/STDs
☐Hyper Pigmentation	☐Hypo Pigmentation	☐Insomnia
☐Joint/Muscle Pain	☐Keloid Scarring	☐Loss of Sensation
☐Low Blood Pressure	☐Lupus	☐Metal Implants
☐Numbness	☐Phlebitis	☐Plates/Pins
☐Scarring	☐Sinus Infection	☐Skin Sensitivities
☐Surgery: _____	☐Precancerous Lesions	☐Pregnant/Nursing
☐Rosacea	☐Psoriasis	☐Rashes
☐Respiratory Conditions	☐Seborrhea	☐Shingles
☐Skin Cancer	☐Hyper/Hypo Thyroid	☐Varicose Veins
☐Warts	☐Other: _____	

Please explain any of the conditions that you checked above: _____
_____
_____
_____
_____
_____
_____

Are you currently taking any medications, vitamins, or supplements? ☐Yes ☐No
If yes, please list: _____

Have you used Accutane within the last year? ☐Yes ☐No

Have you had any facial or dermatology services in the past 30 days? ☐Yes ☐No
If yes, please explain: _____

Do you have any allergies? ☐Yes ☐No
If yes, please explain: _____

Skin Care History

Check the products that you currently use (please select all that apply):

☐ Body Lotion	☐ Body Soap	☐ Body Scrub
☐ Cleansing Brush	☐ Cleansing Gel/Cream/Oil	☐ Day Cream
☐ Eye Makeup Remover	☐ Eye Cream	☐ Exfoliants
☐ Facial Masks	☐ Facial Soap	☐ Facial Scrub/Polisher
☐ Facial Serums	☐ Hand Cream	☐ Makeup
☐ Neck Cream	☐ Night Cream	☐ Skin Toner/Astringent
☐ Sunscreen/Sunblock	☐ Other: _____	

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety	☐ Fatigue	☐ Forgetfulness	☐ Headache
☐ Inflammation	☐ Insomnia	☐ Muscle Cramps	☐ Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐ Acne/Breakouts	☐ Blackheads/Whiteheads
☐ Broken Capillaries	☐ Clogged Pores
☐ Dark Spots	☐ Dryness
☐ Excessive Oil/Shine	☐ Redness
☐ Rosacea	☐ Scarring
☐ Sun Damage	☐ Uneven Skin Tone
☐ Unwanted Hair	☐ Wrinkles/Fine Lines
☐ Other: _____	

Have you been under the care of a dermatologist within the past year? ☐Yes ☐No
If yes, please explain: _____

Have you used Retin-A, Renova, AHAs/BHAs or Retinal/Vitamin A products in the last three months? ☐Yes ☐No
If yes, please explain: _____

Have you received Fillers, Botox, Restylane, or Collagen injections in the last 6 months?
☐Yes ☐No

By signing below, I agree to the following:
I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
_____	_____	_____