Client Consultation

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Cell Phone: _____ Email Address: _____

Employer: _____ Occupation: _____

Does your job require that you work outdoors? Yes _____ No _____

How did you hear about us? _____

Were you referred by anyone? Yes _____ No _____ If yes, who? _____

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

Any known allergies (Latex, medicine, shellfish, cosmetics?): _____

_____

Your Skin Care

1. Have you ever had a facial treatment before today? Yes____ No_____ If yes, when? ___
2. Which of the following best describes your complexion? (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

3. Do you have any special skin problems or concerns pertaining to your face or body? Yes/No
4. Have you ever had chemical peels, laser, or microdermabrasion? Yes/No

   In the last month? Yes/No

5. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? Yes/No
   a. Describe: _____
   b. Have you used any of these products in the last 3 months? Yes/No
6. Have you used and acne medication? Yes/No If yes, when? _____ Which drug? _____
7. What skincare products are you currently using? _____
   _____
   _____
8. Have you recently used any self-tanning lotions, creams, or treatments? Yes/No Specify_____

9. Have you used any of the following hair removal methods in the past six weeks? (circle all that apply and list areas used on and last time each method was used)
   Shaving _____ Waxing _____ Electrolysis _____
   Tweezing _____ Stringing _____ Depilatories_____
10. What areas of concern do you have regarding your skin? (please circle any that apply and explain)

Breakouts/Acne	Uneven skin tone	Sun Damage
Blackheads/Whiteheads	Excessive oil/shine	Wrinkles/Fine lines
Rosacea	Dull/Dry skin	Flaky skin
Broken Capillaries	Redness/Ruddiness	Dehydrated skin
Sun spot/liver spot/brown spot	Other: _____	

Eyes:

Dehydrated Wrinkles Puffiness Dark Circles Other: _____

Lips:

Dehydrated Cracked/chapped lips Other: _____

11. What SPF do you use on your face? _____ How often/when? _____
12. What SPF do you use on your body? _____ How often/when? _____
13. Have you had any recent tanning bed or sun exposure that changed the color of your skin? Yes/No Specify:_____
14. Have you ever had Botox, Restylane, or Collagen injections? Yes/No
    Specify:_____

Female Clients Only:

15. Are you taking any oral contraceptives: Yes/No
    Specify: _____
16. Any recent changes to or from your contraceptive treatment? Yes/No
    If so, what and when? _____
17. Are you pregnant or trying to become pregnant? Yes/No
18. Are you Lactating? Yes/No
19. Any menopause problems? Yes/No
    Specify: _____
20. Are you undergoing any hormone replacement therapy? Yes/No
    Specify: _____

Male Clients Only:

21. What is your current shaving system? Wet shave -or- Electric
22. Do you experience irritation from shaving? Yes/No Ingrown hairs? Yes/No

_____

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: _____

No Show Policy _____ Initials 24-hour notice required or you may be charged
No refunds _____ Initials (We take pride in, stand by, and guarantee our work at Flawless Skin Lounge, if you are unsatisfied with a service we would like you to consult and communicate with your service provider and together come up with a solution.)
Photo Release _____ Initials – My photos can be used in marketing on Social Media or our Website (If you do not want your photos to be used for marketing, do not initial above.)
Skin Lesion Removal _____ Initials
Chemical Peels _____ Initials
Microdermabrasion_____ Initials
Dermaplaning _____ Initials
Microdermabrasion or Dermapeel Combo _____ Initials
Collagen Induction Therapy _____ Initials
IPL/Photo Facial _____ Initials
Eyelash Perming/Tinting/Extensions _____ Initials
Microblading _____ Initials
Face and Neck Tightening _____ Initials
Fat Freezing/Cool Slimming _____Initials
Laser Hair Removal _____ Initials
Injection (Dysport/Restylane/B-12) _____ Initials
Airbrush tanning _____ Initials
Microneedling _____ Initials
Waxing _____ Initials

Client Signature:_____ Date:_____

Aesthetician Signature:_____ Date:_____