

Client Consultation



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	Dark Brown Complexion	Rarely 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: _____

Continued ⇨

Client Consultation—continued

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

8) Have you used an acne medication? ☐ No ☐ Yes, when? _____ Which drug? _____

Soap _____

Shower Gels _____

Toner _____

Body Lotions _____

Mask _____

Sunscreen _____

Eye Product _____

SPF _____

Cleanser _____

Night Moisturizer/Cream _____

Day Moisturizer _____

Other _____

Exfoliator _____

Makeup Products _____

Scrubs _____

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

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)

If yes, please 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"/>		

Continued ⇨

Client Consultation—continued

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

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)

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: _____