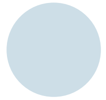
# Client Consultation



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 | Black Complexion | Never burns, deeply pigmented |

4) Do you have any special skin problems or concerns pertaining to your face or body? ❍ Yes ❍ No

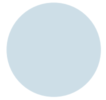
specify: __________________________________________________________________________________

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



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 ❏ Uneven skin tone ❏

Blackheads/whiteheads ❏ Sun damage ❏

Excessive oil/shine ❏ Wrinkles/fine lines ❏

Rosacea ❏ Dull/dry skin ❏

Broken capillaries ❏ Flaky skin ❏

Redness/ruddiness ❏ Dehydrated ❏

Sun spot/liver spot/brown spot ❏ 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 ❏ AHAs ❏

Medicine ❏ Fragrance ❏

Food ❏ Shellfish ❏

Animals ❏ Latex ❏

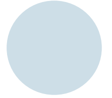
Sunscreens ❏ Drugs ❏

Iodine ❏ Other ____________________________________

Pollen ❏

If yes, please explain: ____________________________________________________

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:_____________