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: _____

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 _____
Toner _____
Mask _____
Eye Product _____
Cleanser _____
Day Moisturizer _____
Exfoliator _____
Scrubs _____

Shower Gels _____
Body Lotions _____
Sunscreen _____
SPF _____
Night Moisturizer/Cream _____
Other _____
Makeup Products _____
_____

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	❑	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)
If yes, please explain: _____

Cosmetics	❑	AHAs	❑
Medicine	❑	Fragrance	❑
Food	❑	Shellfish	❑
Animals	❑	Latex	❑
Sunscreens	❑	Drugs	❑
Iodine	❑	Other_____	
Pollen	❑		

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:_____

Informed Consent: Light-Emitting Diode (LED) Therapy

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your LED treatment, please be aware of the following information and possible risks. Please initial:

___ I understand there are certain contraindications that would preclude me from receiving LED treatments, including epilepsy, medications causing light sensitivity, open wounds, pregnancy, and thyroid conditions.

___ I understand there are other precautions that should be considered before receiving LED therapy treatments and may require a doctor's release and/or I assume any risk involved.

___ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

___ I understand that some clients report slight tingling sensations and flashing of the optic nerve during the procedure.

___ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

___ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the LED procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (Printed) _____

Client Name (Signature) _____Date:_____

Skin care specialist_____