Client Consultation Card

General

Client Name:_____Date:_____Address: _____
City:_____State: _____ Zip: _____Phone Number: _____ Cell Home Work (circle)
Email: _____Birthday: _____Age: ☐ Under 21 ☐ 21-30 ☐ 31-40 ☐ 41-50 ☐ 51-60 ☐ 61+
Emergency Contact: _____ Phone: _____
What are your primary skin care goals/concerns?_____
What other treatments are you interested in? (circle all that apply):
Facial Treatment Waxing Spa Treatment Body Treatment

Skin

Have you had chemical peels, microdermabrasion, or any resurfacing treatments? If yes, specify: _____
Do you use any prescription skin products (i.e. Accutane, Retin-A, Renova, Adapalene) If yes, specify: _____
Please circle all that apply:
Are you currently using any products that contain any of the following ingredients?
Glycolic Acid Lactic Acid Salicylic Acid Exfoliating Scrubs Vitamin A Derivatives
Do you have a tendency to redness? Do you experience an oily shine throughout the day?
Do you ever experience skin breakouts?
What are you using in your current skin care regime (check all that apply and specify brand and type): Soap ☐ _____
Cleanser ☐ _____Toner ☐ _____Exfoliator ☐ _____
Moisturizer ☐ _____Sun Protection ☐ _____Mask ☐ _____
Specialty ☐ _____Eye Treatment ☐ _____Other Products: _____
Male Clients only:
What products do you use during your shaving regime?_____
Do you experience shaving irritation/ingrown hairs? ☐ yes ☐ no
How many times do you shave per week? ☐ 0-2 ☐ 3-5 ☐ 6-7 ☐ 7+

Health

Have you been under a physician's care within the last year? ☐ yes ☐ no If yes, specify:_____
List any regularly taken medications, vitamins, supplements, etc..._____
Please circle all that apply:
Blood Pressure Heart Problems Pacemaker Diabetes Epilepsy Asthma Sinus Problems Hormonal Problems Cold Sores
Claustrophobia Recent Dental X-rays Metal Implants or Body Piercings Vericose Veins: If yes, specify location: _____
Have you had allergic reactions to any of the following: Fragrances: If yes, specify:_____
Food: If yes, specify:_____ Animals: If yes, specify: _____
Medicine: If yes, specify:_____ Cosmetics: If yes, specify:_____
Specific Ingredients: If yes, specify: _____Other: _____
Other health issues: ☐ yes ☐ no If yes, specify: _____
_____
Female Clients only:
Are you taking oral contraception? ☐ yes ☐ no Currently having or due for your menstrual period? ☐ yes ☐ no
Are you pregnant or trying to become pregnant? ☐ yes ☐ no Are you currently breast feeding? ☐ yes ☐ no

Lifestyle

Do you exercise regularly? ☐ yes ☐ no Do you follow a restricted diet? ☐ yes ☐ no If yes, specify:_____
How much water do you intake daily? _____
How many alcoholic beverages do you consume weekly? ☐ 0-1 ☐ 2-6 ☐ 6+
How many caffeinated beverages do you consume daily? ☐ 0-2 ☐ 2-4 ☐ 4+
Do you smoke? ☐ yes ☐ no Rate your stress level on a scale of 1 to 5 (1=lowest, 5=highest). ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Do you sunbathe or use tanning beds? ☐ yes ☐ no If yes, how often? _____
I acknowledge that this information is accurate to the best of my knowledge.
Please note that you will be asked to sign this each time you receive a treatment to verify that all Consultation Card information is updated and accurate.

Signature_____ _____ _____ _____ _____
Date Date Date Date