FACIAL CONSULTATION FORM

ALL INFORMATION IS CONFIDENTIAL

Today's Date: _____

Name:_____ Birthday:_____

Address:_____

City:_____ State:_____ Zip code:_____

Home Phone #:_____Work Phone #: _____Occupation:_____

Marital Status:_____Male: ____Female :____Emergency Contact:_____ #: _____

MEDICAL HISTORY

Check Box Where Applicable/Fill In With Details:

( ) Accutane	( ) Acne	( ) Allergies:_____
( ) Arthritis	( ) Depression	( ) Any Metals in Body
( ) Epilepsy	( ) Diabetic	( ) Heart Condition ( ) Pacemaker
( ) Fever Blisters	( ) Eczema	( ) Blood Pressure ( ) high () low
( ) HIV	( ) Hepatitis	( ) Hyper/Hypo Pigmentation
( ) Lupus	( ) Insomnia	( ) Hyper/Hypo Thyroid
( ) Plastic Surgery	( ) Pregnant	( ) Medications: _____
( ) Psoriasis	( ) Retin-A	( ) Planning on getting Pregnant
( ) Vitamins	( ) Seborrhea	( ) Skin Cancer
( ) Rashes	( ) Shingles	( ) Surgeries:_____
( ) Warts	( )Other: _____	

PERSONAL SKIN CARE HISTORY

Check Current Products you use:

( ) Eye Make-Up Remover	( ) Cleansing Cream	( ) Facial Soap	
( ) Day Cream	( ) Night Cream	( ) Eye Cream	( ) Skin Toner / Astingent
( ) Mask	( ) Facial Scrub	( ) Exfoliants	( ) Neck Cream
( ) Body Lotion/Cream	( ) Body Scrub	( ) Hand Cream	( ) EBody Soap

PERSONAL EVALUATION QUESTIONNAIRE

Please Reply In Detail To the Following Questions:

1. How did you hear about us?

_____

2. What is your major reason for being here today?

_____

_____

(Continued)

3. What skin type and/or problem do you feel you have?

_____

_____

4. Have you ever had a facial treatment before? If yes, where and when? Was it a beneficial experience?

_____

_____

5. Have you ever had a reaction to a food, cosmetic, or skin care product? If yes, please give details:

_____

_____

6. Where do you purchase most of your face and body care products?

_____

7. How much time do you spend on your daily skin care/make-up routine?

_____

8. How you feel about your skin conditions? What would you like to improve?

_____

_____

9. Do you tend to tan or burn? _____
10. Do you smoke or drink? How often? _____
11. Do you exercise and how often? _____
12. How much sleep do you get per night? _____
13. Are you interested in long or short term spa treatment? _____
14. Are you pleased with your current products: _____
15. Have you ever been waxed? _____

I understand and agree to comply with all the salon and spa policies listed below:

1. We do not wax anyone on Accutane, Retin-A, or other medications/products that exfoliate or thin the skin. We do not wax anyone undergoing chemotherapy or radiation treatments.
2. We will not treat clients with questionable medical conditions such as Herpes Simplex (cold sores, fever blisters), open wounds or sores, healing incisions, infectious diseases, etc. We do not massage clients undergoing cancer, diabetes, or systemic treatments or any other specific contra-indications for the body.
3. **We require a minimum of 24 hours advance cancellation notice.** Any client giving less will be charged up to 100% of the service price.
4. I understand that services received here are not a substitute for MEDICAL CARE and any information provided by the technician is for educational purposes only.
5. All information received by the client on this chart, is completely private and confidential.
6. We do not give cash refunds.
7. Defective products must be returned within ten (10) days of purchase to receive credit.
8. Gift Certificates are non-refundable and must be **used within a year** to avoid monthly inactivity fees.
9. A**LL SALES ARE FINAL**

_____ ____ _____

NAME DATE