Client Consultation Form

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____

Sex: ☐ Female ☐ Male ☐ Other What is your preferred pronoun? _____

How were you referred to us? _____

Occupation: _____ Does your job require that you work outdoors? ❍ No ❍ Yes

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

   If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

☐	Type I	Fair skin tones—Always burns, never tans
☐	Type II	Light skin tones—Burns easily, tans slightly
☐	Type III	Fair to olive skin tones—Burns moderately, tans moderately
☐	Type IV	Light brown skin tones—Burns slightly, tans easily
☐	Type V	Dark brown skin tones—Rarely burns, tans easily
☐	Type VI	Dark brown to black skin tones—Never burns, tans easily

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

   If yes, please specify: _____

5) Have you ever had chemicals peels, laser treatments, or microdermabrasion? ❍ No ❍ Yes

   In the last month? ❍ No ❍ Yes

6) Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products? ❍ No ❍ Yes

   If yes, please specify what and when last used: _____

7) Have you used acne medication? ❍ No ❍ Yes, when? _____ Which medication? _____

8) Have you experienced Botox, Restylane, or collagen injections? ❍ No ❍ Yes

   If yes, please specify: _____

9) What skin care products are you currently using? (List brands if known)

Cleanser _____ Toner _____

Day Moisturizer _____ Night Moisturizer _____

Exfoliator _____ Mask _____

Eye Product _____ SPF/Sunscreen _____

Scrubs _____ Makeup Products_____

Soap _____ Shower Gels _____

Body Lotions _____ Other _____

10) Have you used any hair removal methods in the past six weeks? ❍ No ❍ Yes (Check all that apply)
☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing
☐ Stringing ☐ Depilatories ☐ Other: _____

11) Do you experience irritation from shaving? ❍ No ❍ Yes

If yes, please specify: _____

12) Do you experience ingrown hairs as a result of hair removal? ❍ No ❍ Yes

13) What areas of concern do you have regarding your: **Skin** (Check all that apply)
☐ 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/liver/brown spots ☐ Other: _____

Eyes (Check all that apply)
☐ Dehydrated ☐ Wrinkles ☐ Puffiness
☐ Dark circles ☐ Other: _____

Lips (Check all the apply)
☐ Dehydrated ☐ Cracked/chapped lips ☐ Other: _____

14) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____
☐ Cosmetics ☐ AHAs ☐ Medication
☐ Fragrance ☐ Food ☐ Shellfish
☐ Animals ☐ Latex ☐ Sunscreens
☐ Drugs ☐ Iodine ☐ Pollen
☐ Other: _____

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

16) Have you recently used any self-tanning lotions, creams, or treatments? ❍ No ❍ Yes

If yes, please specify: _____

17) Have you had any recent tanning bed or sun exposure that changed the color of your skin? ❍ No ❍ Yes

If yes, please specify: _____

HEALTH HISTORY

18) Are you taking any oral contraceptives? ❍ No ❍ Yes

If yes, please specify: _____

19) Have you experienced any recent changes to or from your contraceptives? ❍ No ❍ Yes

If yes, please specify what and when: _____

20) Are you pregnant or trying to become pregnant? ❍ No ❍ Yes

21) Are you experiencing any menopausal symptoms? ❍ No ❍ Yes

If yes, please specify: _____

22) Are you currently undergoing any hormone therapy treatments? ❍ No ❍ Yes

If yes, please specify: _____

LIFESTYLE

23) How many glasses of water do you drink per day? (Please check one)
☐ <1 glass ☐ 1-3 glasses ☐ 4-7 glasses ☐ 8+ glasses

24) How many caffeinated beverages (coffee, tea, soda, etc.) do you consume per day? (Please check one)
☐ None ☐ 1-2 drinks ☐ 3-5 drinks ☐ 6+ drinks

25) How many alcoholic beverages do you consume per week? (Please check one)
☐ I don't drink ☐ 1-3 drinks ☐ 4-7 drinks ☐ 8+ drinks

26) How many hours of sleep do you get per night? (Please check one)
☐ <3 hours ☐ 3-5 hours ☐ 6-8 hours ☐ 8-10 hours ☐ 10+ hours

27) Which foods do you consume on a regular basis?
☐ Fruits ☐ Vegetables ☐ Dairy/Eggs ☐ Cheese ☐ Poultry
☐ Fish ☐ Grains/Bread ☐ Processed Sugar ☐ Processed Meats

28) What does your daily commute look like?
☐ Car ☐ Bike ☐ Public Transport ☐ Walk ☐ I don't commute

29) How often do you travel on a plane?
☐ Never ☐ 1-2 times per year ☐ 1-2 times per quarter ☐ Every month ☐ Every week

30) How many hours do you spend in front of a screen or digital device?
☐ <3 hours ☐ 4-6 hours ☐ 7-9 hours ☐ 10-12 hours ☐ 12+ hours

31) Do you exercise on a regular basis? ❍ No ❍ Yes

32) Do you smoke cigarettes, vape, or consume other tobacco products? ❍ No ❍ Yes

33) What are your stress levels on a scale from 1 to 5 (1 = low stress, 5 = high stress)? _____

FUTURE APPOINTMENTS/CONTACT

May I call you at the provided 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 the technician/esthetician/skin care professional from liability and assume full responsibility thereof.

Client Name (Printed): _____

Client Name (Signature): _____ Date: _____