Facial Consultation Form

CLIENT INFORMATION

Name, gender, and date of birth: _____

Address:

Contact number/s: _____ **Email address:** _____

Work outdoors for job?

◯ Yes ◯ No

What would you like to achieve from your treatment today?

HISTORY

1. Have you ever had a facial treatment before?

◯ Yes ◯ No

If yes, what kind and when: _____

2. Have you ever had a body spa treatment before?

◯ Yes ◯ No

If yes, what kind and when: _____

3. How would you describe your skin type?:

4. Do you have any skin problems?

◯ Yes ◯ No

If yes, please describe:

5. Have you had laser, chemical peel, microdermabrasion?

◯ Yes ◯ No

If yes, when: _____

6. Do you use retinol or vitamin A products?

◯ Yes ◯ No

If yes, which ones and when:

7. Have you taken acne medication?

◯ Yes ◯ No

If yes, which ones and when:

8. Have you used self-tanning products?

◯ Yes ◯ No

If yes, which ones and when:

9. Have you undergone any hair removal methods?

◯ Yes ◯ No

If yes, which ones and when: _____

10. Do you have any allergies?

◯ Yes ◯ No

If yes, what are they:

11. Have you undergone injection treatments?

◯ Yes ◯ No

If yes, what are they and when:

12. Are you undergoing hormone replacement therapy?

◯ Yes ◯ No

If yes, please elaborate:

PRODUCT USE

Indicate brands used for the products below.

Soap: _____ Shampoo: _____

Toner: _____ Eye product: _____

Cleanser: _____ Day moisturizer: _____

Exfoliator: _____ Scrubs: _____

Shower gels: _____ Body lotions: _____

Sunscreen (specify face/body, SPF):

Night moisturizer/cream: _____ Makeup products: _____

Other: _____

CONCERNS

Skin:

Eyes:

Lips:

Others:

FOR FEMALE CLIENTS ONLY

1. Are you taking oral contraceptives?

◯ Yes ◯ No

If yes, what is the brand: _____

2. Were you using other contraceptives before oral contraceptives?

◯ Yes ◯ No

If yes, what kind and when did you switch:

3. Are you pregnant or trying to become pregnant?

◯ Yes ◯ No

4. Are you lactating?

◯ Yes ◯ No

5. Problems with menopause?

◯ Yes ◯ No

If yes, what are they:

FOR MALE CLIENTS ONLY

1. What is your current method of shaving?

2. Problems like skin irritation or ingrown hairs?

◯ Yes ◯ No

If yes, please elaborate:

Is there anything else you would like to elaborate further on any question or concern you may have? Specify below:

I have read and understood this form completely and answered it truthfully to the best of my abilities. I understand that withholding information or providing misinformation may result in skin irritation and/or contraindications from the treatment/s I will receive. 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's signature:

Date: _____ dd / mm / yyyy