CLIENT INFORMATION
For Facial Treatments

NAME ____

Date ______________________ Referred by ____

Which conditions would you like to improve?

___ Hyperpigmentation ___ Sun damage ___ Acne scarring

___ Age spots ___ Fine lines & wrinkles ___ Acne

___ Enlarged pores ___ Skin tone ___ Facial scars

___ Other – please specify

Health History:

In the past year, have you been under a doctors care? ___ Yes ___ No

If yes, please explain ____

Are you allergic to any medications or cosmetics? ___ Yes ___ No

Nuts, Iodine? ___ Yes ___No Nylon or Silver? ___ Yes ___ No Bee products? ___ Yes ___ No

If yes, please specify ____

Are you allergic to aspirin? ___ Yes ___ No

List any medications you are currently taking ____

Do you smoke? ___ Yes ___ No

Are you currently or have you in the past taken Coumadin or any other blood thinners? ___ Yes ___ No

If yes, how long ago? ____

Are you using an oral acne medication such as Accutane? ___ Yes ___ No

Please check if you have or have had any of the following and give date:

___ High blood pressure ___ Fever blisters ___ Cardiac problems ___ Pacemaker

___ Skin cancer ___ Cancer ___ Psoriasis ___ Seizures

___ Diabetes ___ HIV ___ Epilepsy ___ Currently Pregnant

___ Eczema ___ Hepatitis ___ Metal bone plates/pins

Exfoliation History:

Have you ever had chemical peels, microdermabrasion or any resurfacing treatments? ___ Yes ___ No

If yes, how long ago? ________________________________ Did you have any negative reactions from it? ___ Yes ___ No

If yes, please explain ____

How often do you exfoliate at home? ____

Are you currently using any products that contain the following ingredients?

___ Glycolic Acid ___ Lactic Acid ___ Salicylic Acid ___ Vitamin A derivitives (ie. Retin A, Retinol, Renova)

Moisture / Hydration:

How much plain water do you consume daily? ____

Do you ever experience these conditions in your skin? ___ Flakiness ___ Tightness ___ Overly Dry

Oil Secretion:

Do you ever experience oily shine during the day? ___ Yes ___ No

Do you experience skin breakouts? ___ Yes ___ No

If yes, how often? ____

Do you use products for breakouts or acne? ___ Yes ___ No

If yes, what products? ____

Capillary Activity:

Do you burn easily in moderate sunlight? ___ Yes ___ No

Do you blush easily when nervous? ___ Yes ___ No

Do you have a tendency towards redness? ___ Yes ___ No

Do you suffer from sinus problems? ___ Yes ___ No

Sun Protection:

Do you use sunscreen protection on your face and neck? ___ Yes ___ No What number SPF? _______________

Do you sunbath or use tanning beds? ___ Yes ___ No

Skin Type Conditions:

How would you categorize your skin: ___ Dry ___ Normal ___ Combination ___ Oily ___ Sensitive

What skin care products are you currently using? Circle all that apply

SOAP CLEANSER SCRUB MOISTURIZER EYE CRÈME SPECIALTY SERUMS

What brands do you use? ____

To be signed by client:

I fully understand the questions above and have answered them correctly and honestly. I know it is my responsibility to alert the Esthetician about any recent surgeries, resurfacing, Botox or filler injections as well as any medications I may be taking. Without the above disclosure, I understand that the attending Esthetician cannot optimize the effectiveness of the treatments I wish to have performed. I also understand that without the correct disclosure, I cannot hold the Esthetician or Bella Vita Spa and Salon responsible for any problems that may occur during or after my treatment.

____ ______________________________

Signed by client **Date**