

UNIQUE TO YOU Client Consultation Form



Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____ Married: ___ No ___ Yes Anniversary: _____

Referred by: _____

What would you like to achieve from your treatment today? _____

Your Skin Care

Please circle appropriate answers

1) Have you ever had a facial treatment before? No Yes - When? _____

2) Have you ever had a body spa treatment before? No Yes - When? _____

Treatment Type: _____

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

Type	Features	Characteristics
I	pale white skin red or blond hair blue eyes freckles	always burns, never tans
II	white or fair skin red or blond hair blue, hazel, or green eyes	usually burns, tans with difficulty
III	cream white or fair skin any eye or hair color	gradually tans, sometimes has a mild burn
IV	light brown or olive skin	tans with ease, rarely burns
V	dark brown skin	tans very easily, very rarely burns
VI	deeply pigmented dark brown	tans very easily, never burns

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

5) Have you ever had chemical peels, laser or microdermabrasion? ? No Yes In the last month? No Yes

6) Do you use Accutane, Retin-A, or Retinol/Vitamin A derivative products? No Yes

In the last 6 months? No Yes Describe: _____

7) Are you currently using an acne medication? No Yes Type/Brand _____

8) What skin care products are you currently using? (List brand where known)

Cleanser _____ Shower Gels _____

Toner _____ Body Lotions _____

Mask _____ Sunscreen & SPF _____

Eye Product _____ Night Moisturizer _____

Day Moisturizer _____ Makeup Products _____

Exfoliator _____ Other _____

UNIQUE TO YOU Client Consultation Form - Continued



9) Are you currently using products containing any of the following? Circle all that apply:

Glycolic Acid Salicylic Acid Lactic Acid Hydroquinone

10) Have you used any of the following hair removal methods in the past six weeks? Circle all that apply:

Shaving Waxing Electrolysis Tweezing Threading Depilatories

11) What areas of concern do you have regarding your skin: (Please check any that apply)

<input type="checkbox"/> Breakouts/acne	<input type="checkbox"/> Uneven skin tone
<input type="checkbox"/> Blackheads/whiteheads	<input type="checkbox"/> Sun damage
<input type="checkbox"/> Excessive oil/shine	<input type="checkbox"/> Wrinkles/fine lines
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Dull/dry skin
<input type="checkbox"/> Broken capillaries	<input type="checkbox"/> Flaky skin
<input type="checkbox"/> Redness/ruddiness	<input type="checkbox"/> Dehydrated
<input type="checkbox"/> Sun spot/liver spot/brown spot	<input type="checkbox"/> Other _____

12) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)

<input type="checkbox"/> Cosmetics	<input type="checkbox"/> AHAs/Benzol Peroxide
<input type="checkbox"/> Medicine	<input type="checkbox"/> Fragrance
<input type="checkbox"/> Food/Fruits	<input type="checkbox"/> Shellfish
<input type="checkbox"/> Milk/Dairy	<input type="checkbox"/> Nuts/Gluten
<input type="checkbox"/> Animals	<input type="checkbox"/> Latex
<input type="checkbox"/> Sunscreens	<input type="checkbox"/> Drugs (including Aspirin/Sulfa)
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pollen	

If yes, please explain: _____

Female Clients Only:

Are you taking oral contraceptives? No Yes
Are you pregnant or trying to become pregnant? No Yes Are you lactating? No Yes

Male Clients Only:

What is your current shaving system? Wet shave _____ Electric _____
Do you experience irritation from shaving? No Yes Ingrown hairs? No Yes

May I call you at your home or cell 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 skin care professional from liability and assume full responsibility thereof.

*I understand that a **24 hour advance notice is required** when canceling an appointment. If unable to give 24 hours advance notice I may be charged **half the amount** of my appointment, to be paid prior to my next scheduled appointment.*

I understand if I forget or consciously choose to forgo my appointment for whatever reason, I will be considered a "no-show" and may be fully charged for the "missed" appointment.

*I understand if I arrive late, my session may be shortened in order to accommodate others whose appointments follow mine and **will be responsible for the "full" session.***

Client Signature: _____ Date: _____