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)

_____Breakouts/acne
_____Blackheads/whiteheads
_____Excessive oil/shine
_____Rosacea
_____Broken capillaries
_____Redness/ruddiness
_____Sun spot/liver spot/brown spot
_____Uneven skin tone
_____Sun damage
_____Wrinkles/fine lines
_____Dull/dry skin
_____Flaky skin
_____Dehydrated
_____Other _____

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

_____Cosmetics
_____Medicine
_____Food/Fruits
_____Milk/Dairy
_____Animals
_____Sunscreens
_____Iodine
_____Pollen
_____AHAs/Benzol Peroxide
_____Fragrance
_____Shellfish
_____Nuts/Gluten
_____Latex
_____Drugs (including Aspirin/Sulfa)
_____Other_____

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:_____

UNIQUE TO YOU Confidential Client Health History Form

Date: _____ Name: _____

Emergency Contact: _____ Phone: _____

Please circle appropriate answers:

1) List any medical conditions: _____
Name of Physician _____ Phone _____
Name of Dermatologist _____ Phone _____

2) Any recent surgery, including plastic surgery? No Yes, explain: _____

3) Any skin cancer? No Yes, explain: _____

4) Have you had any of these health conditions in the past or present? (Please check all that apply and provide additional information in the space provided)

_____Cancer	_____Hormone imbalance	_____Systemic disease
_____High blood pressure	_____Spinal injury	_____Thyroid condition
_____Hysterectomy	_____Diabetes	_____Heart problem
_____Varicose veins	_____Arthritis	_____Asthma
_____Eczema	_____Epilepsy	_____Seizure disorder
_____Fibromyalgia	_____Headaches (chronic)	_____Hepatitis
_____Herpes	_____Frequent cold sores	_____Lupus
_____Autoimmune disorders	_____HIV/Aids	_____Other _____
_____Skin diseases/lesions	_____Any active infection	

_____Phlebitis, blood clots, poor circulation, blood clotting abnormalities

Current prescription medications are taken for: _____
_____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take regularly:
_____

5) Do you smoke? No Yes
6) Do you form thick or raised scars from cuts or burns? No Yes
7) Do you wear contact lenses? No Yes
8) Have you been exposed to the sun or used a tanning bed in the last 48 hours? No Yes
9) Do you have any metal implants or wear a pacemaker? No Yes
10) Have you ever experienced claustrophobia? No Yes

Please use this space to complete answers where space was insufficient. (Please include the number of the question)
_____
_____
_____

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. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release skin care professional from liability and assume full responsibility thereof.

Client Signature: _____ Date: _____