The Garden Day Spa & Salon

 CONFIDENTIAL SKIN CARE CONSULTATION

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_/\_\_\_\_\_\_/ 20\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (circle) MALE / FEMALE

HOME PHONE (\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE(\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ESTHETICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FACIAL ANALYSIS

*\*For an effective personalized treatment, please be as accurate as possible.*

**Skin Type**

□ Normal □ Dry □ Sensitive □ Combination □ Oily

□ Sensitive/Breakout □ Very Sensitive/Rosacea

□ Acne □ Mature

**What are your present skin care concerns?**

 *Please check all that apply*

□ Acne Lesions (cysts) □ Papules (inflamed) □ Blackheads

□ Acne Scars □ Pustules (inflamed) □ Whiteheads

□ Dilated Capillaries □ Ingrown Hairs □ Enlarged Pores

□ Hyperpigmentation (brown spots from sun, scars, hormonal)

**Eye Area**

□ Crows Feet/Wrinkles □ Puffiness

□ Lack of Elasticity □ Dark Shadows

**Mouth Area**

□ Wrinkles □ Nasolabial Folds □ Hyperpigmentation

**Cheek Area**

□ Loss of Elasticity □ Cross Wrinkling (sun damage)

□ Hyperpigmentation □ Uneven Texture

□ Dilated Pores □ Visible Capillaries

**Neck & Décolleté Area**

□ Wrinkles □ Lack of Elasticity

□ Severe Sun Damage □ Hyperpigmentation

**How often do you receive a facial?**

□ Regularly □ Seldom □ Never

**Have you recently received any of the following**

**spa services?**

□ Microdermabrasion Date\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Enzyme Peels Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Acid Peels Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Waxing Services Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you received any of the following medical or surgical procedures?**

□ Rhytidectomy (Face Lift) Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Rhinoplasty (Nose) Date\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Blepharoplasty (Eye Lift) Date\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Laser Resurfacing Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Dermabrasion Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Medical Acid Peels Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Collagen Injections Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Restylane Injections Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Botox Injections Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dermatologist/Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you use any of the following?**

□ Eye Make-Up Remover Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Cleanser Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Toner Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Moisturizer Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Exfoliator Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Mask Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Make-Up Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Sunscreen Brand\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you could improve one thing about your skin, what would it be?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Continued on back…………………..

GENERAL HEALTH RECORD

**Have you ever been diagnosed with any of the following skin disorders?**

□ Acne □ Seborrhea □ Eczema

□ Psoriasis □ Skin Cancers □ Rosacea

□ Mycosis (fungal infection) □ Contact Dermatitis

**Do you suffer from any allergies?**

(cosmetic ingredients, food, iodine, medications, hay fever, latex)

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently undergoing chemotherapy or radiation therapy?**

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any medications, herbs, vitamins?**

□ **Internal/Oral**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Topical**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you taken any oral steroids like prednisone in the past 1-2 months?**

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you taken blood thinners in the past 6 months?**

□ No □ Yes (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been prescribed Accutane or any skin-thinning or exfoliating drugs, including Retin-A, Renova, Tazorac, Differin, Glycolic or Alpha Hydroxy Acids(AHAs)?**

□ No □ Yes (please specify drug and last date used)\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand, have read and completed this questionnaire truthfully. 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 skin care professional from liability and assume full responsibility thereof. I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the esthetician in giving better service and is completely confidential.**

 **SPA Policies:**

1. **Professional consultation is required before initial dispensing of products.**
2. **We require a 24-hour cancellation notice.**

**I fully understand and agree to the above spa policies.**

**Client’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/20\_\_\_\_\_\_**

**Esthetician’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/20\_\_\_\_\_\_**

**Do you have any body implants?**

□ Prosthesis □ Metal □ Metal bone pins/plates

□ Dental □ Other, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been diagnosed with any of the following?**

□ Anxiety □ Cancer □ Hemophilia

□ Depression □ Diabetes □ Hepatitis

□ Migraines □ Thyroid □ Herpes

□ Asthma □ Epilepsy □ HIV

□ Sinus Problems □ Heart Problems □ Seizures

□ Lupus □ High Blood Pressure

□ Low Blood Pressure

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do any of the following apply to you?**

□ Smoke □ Exercise □ Have Pacemaker

□ Eat Spicy Foods □ Wear Contact Lenses

**When exposed to the sun, do you?**

□ Burn Easily □ Tan Easily

□ Never Burn □ Never Tan

**How often do you consume alcohol?**

□ Regularly □ Seldom □ Never

**How many glasses of water do you consume daily?**

□ 1-2 □ 3-5 □ 6-8+

**For Women Only……..**

□ Regular Menstruation □ Menopause

□ Pregnant □ Birth Control Pill

□ Lactating □ IUD (copper or plastic)

□ Hormonal Problems