

Facial Client Information Form

Name: _____ Date: _____ Therapist Name: _____

Street Address: _____ City: _____ State: _____

Zip: _____ Telephone () _____ Cellular: () _____

E-mail: _____ Occupation: _____

Date of Birth: _____ under 21 _____ 21-30 _____ 31-40 _____ 41-50 _____ Over 50 _____

Reason for visit? _____ How did you hear about us? _____

Emergency Contact Name: _____ Emergency Contact Number _____

CLIENT HISTORY

Have you had any of these health problems
In the past or present?

- ___ Cancer ___ Hormone Imbalance
- ___ Diabetes ___ Hysterectomy
- ___ Epilepsy ___ Thyroid
- ___ Heart Problem ___ Varicose Veins
- ___ Claustrophobia

Do you smoke? ___ yes ___ no

Had chemical peels? ___ yes ___ no

Use Retin-A? ___ yes ___ no

Used the Acne drug, Accutane? ___ yes ___ no

Have regular sleep patterns _____ yes ___ no

Wear contact lenses? _____ yes ___ no

Have metal implants or pacemaker? ___ yes ___ no

Do you have any special skin problems

Pertaining to your face?

_____ yes _____ no

(Check All That Apply)

_____ Pores _____ Redness

_____ Acne _____ Pigmentation

CAPILLARY ACTIVITY

Do you burn easily in moderate sunlight?

_____ yes _____ no

Do you blush easily when nervous?

_____ yes _____ no

Do you have a tendency to redness?

_____ yes _____ no

What type of massage pressure do you prefer?

_____ yes _____ no

Have you ever had a reaction to any of the following?

- _____ cosmetics _____ pollen
- _____ medicine _____ food
- _____ iodine _____ AHA's
- _____ animals _____ fragrance
- _____ sunscreens _____ other-list:

FEMALE CLIENTS ONLY

Are you pregnant or trying to become pregnant?

_____ yes _____ no

_____ Wrinkles/Aging _____ Scarring

_____ Dryness _____ Hair

Other _____

I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Client Signature

Date

Client Profile Notes

1. _____

Product Recommended/Sold:

Aesthetician: _____ Date: _____

2. _____

Product Recommended/Sold:

Aesthetician: _____ Date: _____

3. _____

Product Recommended/Sold:

Aesthetician: _____ Date: _____

4. _____

Product Recommended/Sold:

Aesthetician: _____ Date: _____