Client Consultation

Name:_____
Address:_____
Cell Phone:_____E-mail:_____
Occupation:_____

What results would you like to achieve from the facial?_____
_____

Have you ever had a facial treatment before? No _____Yes_____If yes, when? _____

Have you ever had chemical peels, laser, or microdermabrasion? No_____ Yes_____
If yes, was it in the last month? No_____ Yes_____

Have you used, or are you currently using, Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? No_____Yes_____

Have you used an acne medication? No_____ Yes_____
If yes, when? _____ Which medication? _____

Have you had Botox, Restylane or collagen injections in the last 4 weeks? No _____ Yes_____

Are you pregnant or nursing? No_____ Yes_____

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

_____ Cosmetics
_____ Food
_____ Shellfish
_____ Animal hair/dander
_____ Pollen
_____ AHAs
_____ Fragrance
_____ Dyes
_____ Nickel
_____ Gold
_____ Latex
Other_____

Client Signature _____ Date _____