

Facial Consultation Form

Name: _____ Date: _____

Date of Birth: _____

Address: _____

Contact Number/s: _____

E-mail Address: _____

How would you like to be contacted? _____

Civil Status: _____

Occupation and Employer: _____

Are you required to work outdoors because of work?

☐ Yes

☐ No

What would you like to achieve from your treatment today?

HISTORY

1. Have you ever had a facial treatment before?

☐ Yes

☐ No

If yes, what and when?

2. Have you ever had a body spa treatment before (i.e. massage, body scrub, seaweed wrap)?

☐ Yes

☐ No

If yes, what and when?

3. How would you describe your skin type? Do you always get sunburned? Do you get tan, and how tan do you get?

4. Do you have any skin problems on your face or body?

☐ Yes

☐ No

If yes, please describe:

5. Have you ever undergone a laser, chemical peel, or microdermabrasion treatment?

☐ Yes

☐ No

If yes, when?

6. Do you use any retinol or vitamin A derivative products?

☐ Yes

☐ No

If yes, which ones and when was the last time you used them?

7. Have you taken acne medication?

☐ Yes

☐ No

If yes, which one and when was the last time you took it?

8. Please identify which of the following products you use and write down the brand for each.

Soap _____

Shampoo _____

Toner _____

Eye Product _____

Cleanser _____

Day Moisturizer _____

Exfoliator _____

Scrubs _____

Shower Gels _____

Body Lotions _____

Sunscreen (Please specify if it's on the face and/or body and what the SPF is)

Night Moisturizer/Cream_____

Other_____

Makeup Products _____

9. Have you used any self-tanning products?

☐ Yes

☐ No

If yes, which ones and when was the last time you used them?

10. Have you undergone any hair removal methods?

☐ Yes

☐ No

If yes, which ones and when was the last time you underwent it?

11. What areas of concern do you have regarding your:

- Skin: _____

- Eyes: _____

- Lips: _____

12. Do you have any allergies?

☐ Yes

☐ No

If yes, what are they? _____

13. Was your skin tanned by tanning bed or sun exposure?

☐ Yes

☐ No

If yes, please elaborate: _____

14. Have you undergone any injection treatments?

☐ Yes

☐ No

If yes, what are they, and when was the last time you underwent the treatment:

15. Are you undergoing hormone replacement therapy?

☐ Yes

☐ No

If yes, please elaborate: _____

For female clients only:

1. Are you taking oral contraceptives?

☐ Yes

☐ No

If yes, what is the brand? _____

2. Were you taking any other contraceptives prior to oral contraceptives?

☐ Yes

☐ No

If yes, what were those, and when did you switch?

3. Are you pregnant or trying to be pregnant?

☐ Yes

☐ No

4. Are you lactating? _____

5. Have you/are you experiencing any problems with menopause?

☐ Yes

☐ No

If yes, what are those? _____

For male clients only:

1. What is your current way of shaving? _____

2. Have you or are you experiencing any problems like skin irritation or ingrown hairs from shaving?

☐ Yes

☐ No

If yes, please elaborate: _____

Is there anything else you would like to elaborate further on any question or concern you may have?

I have read and understood this form completely and answered it truthfully to the best of my abilities. I understand that withholding information or providing misinformation may result in skin irritation and/or contraindications from the treatment/s I will receive. The treatments I receive here are voluntary, and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Signature of Client: _____

Date: _____