ESTHETIC SERVICES

HAVE YOU HAD ANY HEALTH PROBLEMS OR SURGERIES PAST OR PRESENT? ( ) YES ( ) NO
IF SO PLEASE LIST:_____

LIST ANY MEDICATIONS, SUPPLEMENTS, VITAMINS, ETC YOU ARE TAKING REGULARLY:
_____

DO YOU SMOKE? ( ) YES ( ) NO
DO YOU WEAR CONTACTS? ( ) YES ( ) NO
DO YOU HAVE ANY METAL IMPLANTS, A PACEMAKER, OR BODY PIERCINGS? ( ) YES ( ) NO
DO YOU SUNBATHE OR USE TANNING BEDS? ( ) YES ( ) NO
DO YOU HAVE A TENDENCY TO REDNESS? ( ) YES ( ) NO
DO YOU BURN EASILY IN MODERATE SUNLIGHT? ( ) YES ( ) NO
HAVER YOU EVER EXPERIENCED CLAUSTERPHOBIA? ( ) YES ( ) NO
DO YOU EXPERIENCE SKIN FLAKINESS OR DRYNESS? ( ) YES ( ) NO ( ) OCCASIONALLY
DO YOU EXPERIENCE OILY SHINE DURING THE DAY? ( ) YES ( ) NO ( ) OCCASIONALLY
DO YOU EXPERIENCE SKIN BREAKOUTS? ( ) YES ( ) NO ( ) OCCASIONALLY
WHAT TYPE OF MASSAGE PRESSURE DO YOU PREFER? ( ) LIGHT ( ) MEDIUM ( ) FIRM
RATE YOUR STRESS LEVEL (1=LOW): 1 2 3 4

HOW MUCH WATER DO YOU CONSUME DAILY?: _____
HOW MANY ALCOHOLIC BEVERAGES DO YOU CONSUME WEEKLY? _____

DO YOU HAVE ANY SPECIFIC SKIN PROBLEMS- FACE OR BODY? ( ) YES ( ) NO
IF SO PLEASE LIST:_____

WHAT SKIN CARE PRODUCTS ARE YOU CURRENTLY USING?
FACE: ( ) SOAP ( ) CLEANSER ( ) TONER ( ) MOISTURIZER ( ) MASQUE ( ) EXFOLIANT
BODY: ( ) SOAP ( ) SHOWER GEL ( ) SCRUB ( ) OIL ( ) MOISTURIZER ( ) DEPILATORY

HAVE YOU EVER HAD A CHEMICAL PEEL, MICRODERMABRASION, OR RESURFACING TREATMENT?
( ) YES ( ) NO IN THE LAST MONTH? ( ) YES ( ) NO

HAVE YOU RECEIVED BOTOX IN THE LAST 24 HOURS? ( ) YES ( ) NO

DO YOU USE RETIN-A, RENOVA, ADAPALENE, OR ANY PERSCRIPTION SKIN PRODUCTS?
( ) YES ( ) NO IN THE LAST 3 M ONTHS? ( ) YES ( ) NO

ARE YOU CURRENTLY USING ANY PRODUCTS THAT CONTAIN THE FOLLOWING INGREDIENTS?:
( ) GLYCOLIC ACID ( ) LACTIC ACID ( ) ANY EXFOLIATING SCRUB ( ) ANY HYDROXY ACID
( ) VITAMIN A DERIVATIVES (i.e., RETINOL)

ARE YOU ALLERGIC TO ANYTHING? ( ) YES ( ) NO LIST:_____
ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? ( ) YES ( ) NO

HOW OFTEN DO YOU HAVE WAXING DONE? _____
HAVE YOU EVER HAD A REACTION TO A WAXING SERVICE? ( ) YES ( ) NO

I am aware that any service provided to me by my therapist could have unfavorable results including but not limited to: allergic reaction, irritation, burning, redness, soreness, etc. I am aware that certain medications and products can significantly increase the risk of injury when combined with skin care services. I understand that my therapist does not recommend skin care services for customers using Retin A or products any skin thinning treatments and I confirm that I am not using any such medications. I agree that as a condition of being given these services, I will not hold my therapist responsible should there be an unfavorable outcome or result. I understand that esthetic services are not a replacement for medical care and that no diagnosis will be made. I will keep my therapist informed of any changes or arising medical conditions. I know if I fail to do so my therapist is not liable for any problems arising from my treatments. I also understand that any illicit or sexually suggested remarks or advances made by me will result in termination of my session.
CLIENT SIGNATURE:_____ DATE:_____