Facial Consultation

Name: _____ Date: _____

Address: _____

Email: _____ Phone: _____ Cell: _____

DOB: _____

How did you hear about us or who can we thank for your visit today? _____

What would you like to achieve from your treatment today? _____

As with any facial treatment, there are always possible problems that can arise. Everyone's skin is unique and may or may not be sensitive to an ingredient or product. Allergic reactions are not common, but can occur. Always advise your facial specialist if you are on any medication, had recent surgery or have been diagnosed in the past with any skin condition. Redness, swelling, peeling, increased pigmentation, prolonged skin sensitivity to wind and sun, breakouts and skin burning can occur. These side effects are temporary, but can be uncomfortable and upsetting.

The following consent for treatment acknowledges that you understand that the skin is living tissue and responds to each individual differently, and however unlikely, any time you receive a peel, the skin may experience one or more of the above mentioned side effects or be a little sensitive for a day or so.

Personal Data: (please circle yes or no)

Smoker? Yes or No

Are you under the care of a Physician? Yes or No

Any health problems? Yes or No

Do you have any allergies? Yes or No If yes, please explain_____

Do you suntan? Yes or No Do you use sunscreen? Yes or No

Have you ever used Retin-A? Yes or No If yes, what strength? _____

Have you ever used Hydroquinone (skin lightener)? Yes or No

Have you ever been on Accutane? Yes or No If yes, when? _____

Have you had? herpes hives cold sores fever blisters keloids (Circle all that apply)

Please name the brand of the products you are currently using:

Cleanser:_____ Toner:_____

Moisturizer:_____ Scrub:_____

Mask:_____ Exfoliator:_____

Other:_____

Please circle if you have had any of the following:

Diabetes	Liver Inflammation
Herpes	Menopause
Sensitive to Anesthetic	Lupus
Irregular Menses	Heart Problems
Hysterectomy	Hypertension
Sun Allergy	Autoimmune Illness

If you answer yes to the following, please explain:

Skin Cancer	Yes	No	_____
Waxing	Yes	No	_____
Electrolysis	Yes	No	_____
Hypersensitivity to Skin Products	Yes	No	_____
Skin Infections	Yes	No	_____
Tanning within the last 6 weeks	Yes	No	_____
Use of Acne Products/ Drugs	Yes	No	_____
Laser Skin Resurfacing	Yes	No	_____
Chemical Peels	Yes	No	_____
Photo Sensitizing Substances	Yes	No	_____
Laser work of any type	Yes	No	_____

I confirm (to the best of my knowledge) that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or the results thereof. I am aware that there are often inherent risks associated with skin care services including manicures and pedicures, and that the services I am about to receive could have unfavorable results including, but not limited to allergic reaction, irritation, burning, redness, scarring, soreness, etc. By signing below, I further agree that I will not hold A Touch of Moore Day Spa or its affiliates or any of its employees responsible should there be any unfavorable outcome or result.

X_____ X _____ Date: _____

client signature if under 18; Parent signature