

FACIAL CONSENT FORM

Suzi's Skin Care Studio llc.

To assist us in providing you with the proper skincare, we would appreciate your taking a few moments to fill the front Portion of this comprehensive skin analysis record card. It will aid your Esthetician in keeping a closer watch on the progress and Improvement of your skin.

Name: Birthday: Address: City: State: Zip: Cell Phone: Work Phone: Referred by: Email Address (to receive Discounts):

Dermatologist: Phone: Date of 1st visit: Known Allergies: Medications: Please inform us of any of the following problems you are experiencing now with your skin: Flaky Dryness Extra Oily Problem Breakouts Dry Areas: Oily T area Clogged Pores Deep Lines other Concerns

Have you received a facial treatment before and were you happy with The results? what do you expect from your treatment Today?

Are you currently under the care of a dermatologist? If so, for what condition have you ever experienced An allergic reaction to products? Please explain products Used and reactions caused

CURRENT SKINCARE REGIMEN

Cleansing Cream/Lotion Yes No Type & How Often Astringent Yes No Type & How Often Scrub/Peel Yes No Type & How Often Toner Yes No Type & How Often Day Cream/Lotion Yes No Type & How Often Night Cream/Lotion Yes No Type & How Often Eye Cream/Gel Yes No Type & How Often

Do you wash your face morning yes No night yes No Do you use Body Lotion/Cream Yes No? Would you be interested in Self-Tanning Yes No

Have you ever had a massage/body treatment? Do you take birth control pills? Have you given birth? Are you pregnant? Are you anemic? Do you have poor circulation?

Do you smoke? Light Moderate Heavy Do you consume alcohol? Light Moderate Heavy Do you drink caffeinated beverages? How Much Do you consume spicy foods? How Often? Have you ever had eczema/psoriasis? Do you regularly wear foundation or face powder? Do you tan? Do you burn? Have you had cosmetic or laser surgery? Have you had a deep skin peeling? When? Do you have any allergies to anything (scent, ingredients).

IF YES PLEASE BRING TO SALON STAFF ATTENTION!

Are you allergic to latex? We can use essential oil during your facial please let your Esthetician know the essential oil aroma you prefer.

Please make us aware of any of the following conditions you may have. (Please Circle)

Contact Lenses, Pacemaker, Metal Plate/Pins, Retin-A Accutane, Diabetes, Heart Condition, Lupus, Contagious Disease, Epilepsy, High Blood Pressure, Blood Thinner, Thyroid Condition, Asthma, Arthritis, Hepatitis, Phlebitis, Claustrophobia, Implants, Acne

Preferred Massage:

Hand Back Neck/Shoulders Face Feet

Massage Pressure:

Firm Gentle Average Pressure Point Stimulating Relaxing

Preferred Aromas:

Spice Wood Sweet Flowery

I understand and fully agree to comply with all of the treatment policies listed below. I understand that these guidelines are set for health reasons and that they are on the behalf of myself and others.

We do not wax any individual who is on the medication Accutane or Retin-A, or any other medication that thins or exfoliates the skin, anyone receiving radiation treatments or chemotherapy. We will not treat clients with questionable medical conditions such as Herpes Simplex (cold sores, fever blisters, open wounds, sores, healing incisions, infectious, etc.)

I understand that the services received are not a substitute for medical or dermatological attention, and that any information that is provided to me by the esthetician is for educational purposes only and is not to be construed as medical treatment.

All information received by the client on this form is completely private and confidential.

CLIENT SIGNATURE

DATE