

CLIENT INFO

Name

Date

Address

Phone

Email

PERSONAL INFORMATION

1. What are your skin concerns and challenges today?

2. What are you currently using on your skin?

3. Do you have any allergies? Shellfish Iodine Gluten Soy Sulphur Seasonal
Other (Please list)

4. Are you taking any medications for allergies? Yes No

5. Have you ever had an adverse reaction to a cosmetic product? Yes No If yes, please describe.

6. Have you ever had an adverse reaction to a skin care treatment? Yes No If yes, please describe.

7. Have you ever been diagnosed with skin cancer on the face, scalp, neck or v-area? Yes No

8. Do you have any health problems that we need to be aware of? Cancer Diabetes Psoriasis Lupus
 Arthritis High or Low Blood Pressure Other (Please list)

9. Are you currently under a physician's care for any skin disorders? Acne Rosacea Eczema Psoriasis
 Other (please list)

10. Are you pregnant or lactating? Yes No

11. Have you had a chemical peel, laser or microdermabrasion treatment in the last 6 months? Yes No

12. Have you taken Accutane or used Retin-A/Renova within the last 12 months? Yes No If yes, when?

13. Do you tan? (Tanning Booth or Outdoor UV Exposure) Yes No If yes, how often?

14. Do you smoke or vape? Yes No

15. Do you have a pacemaker or any pins in bones? Yes No

16. Are you wearing contact lenses today? Yes No

CHEMICAL PEEL CONSENT

My esthetician may choose to use a surface peeling chemical exfoliant during my facial and I give consent.

Client Signature

Date

Esthetician's Initials

Date