Shelley's Facial Consent Form

Name:____

Phone:_______________________ Cell Phone Provider: ______________

DOB:_____/______/______ (Example AT&T, Verizon)

Address:____

City:_____________________ State:________ Zip:_______________

Email:_____________________ Emergency Contact:_______________

Expectations and History:

- Which conditions would you like to improve?
  _____ Acne Scarring _____ Hyperpigmentation_____ Acne______ Broken capillaries ______Age Spots
  _____ Stretch Marks _____ Enlarged Pores _____ Surgical / Facial Scars ______ Fine lines & wrinkle
- Have you ever had a facial treatment in the past _____ Y_____ N
- If yes explain:_______________________________________
- What special areas of concern do you have? ________________________
- What is the reason for your visit today? __________________________
- Do you ever experience (check all that apply)

_____ Flakiness______ Tightness______ Redness_____ Excessive oily shine during the day

- What is your current skin regimen? (check all that apply)
  ____ Soap & water_____Cleanser______Toner_____Mask_____Moisturizer
  ____Exfoliation _____ Sunscreen every day Other:_______________
- Do you blush easily? _____ Y _____ N
- Do you (check all that apply) ______ Sun Bathe _____ Use a tanning bed
- Have you ever had (check all that apply)____Peels_____Microdermabrasion_____Facial surgery ____Botox _____Cosmetic Fillers _____ Laser Resurfacing
- How recently?_______________
- Are you under treatment for any current skin conditions?________________
- Does your skin heal ______Fast ______Scar _____ Pigment ______ Keloids
- Do you bruise easily? ______Y ______N
- Do you get fever blisters? ______ Y ______N
- What medications/ Hormone replacement/ Vitamins are you currently taking?

  ____
- Have you ever used ____Acutane ____Retin A ____Renova _____Topical Antibiotics _____Tazarac _____Alpha Hydroxy Acids
- Any personal or family history of skin cancer? _____Y _____N
- Have you had any of the following past or present?

  Allergies ____ Y_____N **When/What?**______________________

  Arthritis ____Y ______N Diabetes _____Y_____N Cancer _____Y______N

  Blood Pressure _____Y_____N _____High ______Low ______Normal

  Eczema _____Y _____N Where at on the body?__________________

Cataracts _____Y _____N Epilepsy _____Y_____N Heart Disease _____Y____N
Cholesterol _____Y_____N Infections______Y_____N Menopausal _____ Y ____ N
Pace Maker_____Y_____N Varicose Veins ______Y _____N
Do you smoke____Y_____N Do you wear Contacts _____Y_____N
Have you had a reactions to _____ Cosmetics _____ Metals _____ Medication
_____ Food _____ Fragrance _____ Air Borne Particles
Other:____

For Women: Are you pregnant? ______ Y ______ N
Do you experience hormone imbalances? ______ Y ______ N
For Men: Do you shave with ______ Electric Shaver _______ Razor
Do experience skin breakouts? ______ Y ______ N
How many glasses of water do you consume daily? ______________________________
How many cups of caffeinated beverages do you consume daily? (coffee, tea, soft drinks)_____________

- I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval. ______ Y ______ N
- I am over 18 years of age or I have parental consent. ______ Y ______N

Your provider will recommend the appropriate schedule for future skincare treatments and professional at home care in order to achieve your skin improvement goals.

Please sign below to acknowledge all information is true and correct.

Guest Signature:____

Date:____