



Client Information Form

Name _____

Phone (home) _____ (mobile) _____

Can I text this number? yes no Birthdate _____

Email _____

Occupation _____

How did you hear about us?

Do you want product suggestions today? yes no

What products do you use? Brands: _____

Cleanser Toner Moisturizer Serum Eye cream/gel Mask Exfoliant SPF

Conditions you are currently experiencing today (Please select all that apply):

Headache Inflammation Muscle Cramps Anxiety Fatigue

Insomnia Stress Claustrophobia Forgetfulness

Have you ever had an allergic reaction to any of the following?

Cosmetics Medicine Food Animals Sunscreen Drugs

Iodine Pollen AHAs Fragrance Shellfish Latex

Other: _____

Which aroma/s do you prefer(or do not): _____

What type of skin do you have?

Normal Oily Dry Combination

What areas of concern do you have regarding your skin?

Dull/Dry Skin Dehydrated Uneven Skin Tone Blackheads/Whiteheads
Wrinkles/Fine Lines Redness/Puffiness Sun Damage Rosacea
Sun, Liver, Brown Spots Breakouts/Acne Excessive Oil/Shine Broken Capillaries
Other: _____

Have you been under the care of a dermatologist within the past year? yes no

If yes, please explain: _____

Do you currently or have you used in the last 3 months Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? If yes please describe:

Have you received Botox, Restylane, or Collagen injections in the last 6 months? yes no

If yes, please
specify: _____

By signing below, you agree to the following: I have completed this form to the best of my ability and knowledge and agree to inform the technician of any changes in the above information. I have been informed of and understand the contraindications to the requested treatments and agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liabilities toward my technician for any injury or damages incurred due to any misrepresentation of my health history.

Signature _____

Date _____