



Name _____ DOB ___/___/___ Date ___/___/___

Address _____ City/Zip _____

Phone _____ Email _____

Do you have any health problems I need to be aware of? YES NO

Please describe _____

Do you have any allergies? YES NO

Please describe _____

Are you pregnant? YES NO

Are you taking any medications? YES NO

Any recent surgery? YES NO

Have you ever had an adverse reaction to a cosmetic product? YES NO

Are you currently, or have you taken Accutane in the past 12 months? YES NO

Please describe meds or reaction

Are you currently, or have you used Retin-A, Renova, or any powerful alpha hydroxy acids in the past 3 months? YES NO

Have you had a medical peel in the past 12 months? YES NO

Have you ever had a professional skincare treatment? YES NO

Do you have a pacemaker or any pins in bones? YES NO

Have you ever had an adverse reaction to a skincare treatment? YES NO

Do you wear contacts? YES NO

Please describe _____

Do you have Rosacea? YES NO

What are your skin concerns and challenges?

Are you currently under a physician's care? YES NO

What are you currently using to cleanse your skin? _____

What are you currently using to moisturize your skin? _____

What special treatment products are you using? (eye cream, night cream, masks, serums, exfoliators)

What results would you like to see from today's treatment? _____

SIGNATURE _____ DATE _____



Client Consent Form:

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by _____.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost. I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately. I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically. I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed)

Name (signature)

Date

Client