GREENLEAF
MASSAGE + DAY SPA

SKIN CARE CONSULTATION

Date: _____

Name: _____

Adddress: _____

City: _____ ST: _____ Zip: _____

Primary Phone: ( ) _____

Date of Birth: _____ Email: _____

What is your occupation? _____

How did you learn about Green Leaf Massage + Day Spa?

Have you had skin treatments (facials) before? ☐ Yes ☐ No If yes, when? _____

How would you describe your skin? ☐ Normal ☐ Oily / Acne ☐ Sensitive ☐ Dry ☐ Aging

What conditions would you like to improve? *(please check all that apply)*

☐ Acne/Acne Scarring ☐ Sun Damage ☐ Enlarged Pores ☐ Hyperpigmentation (brown spots)

☐ Fine Lines & Wrinkles ☐ Age Spots ☐ Rosacea ☐ Dry / Dehydration

☐ Other? Please list: _____

Have you had electrolysis or waxing in the past week / or regularly?

Please check if presently using any of the following. *(please check all that apply)*

☐ Accutane ☐ Glycolic Acid/Alpha Hydroxy Acid ☐ Topical Vitamin C ☐ Hydroquinone ☐ Antibiotics

☐ Nicotine ☐ Nutritional Supplements ☐ Contact Lenses ☐ Snore Strips ☐ Biore

☐ Retinoid (Vitamin A derivatives) i.e. Tazorac, Retin A, Renova, Differin

Have you had or have any of the following?

☐ Cosmetic Surgery ☐ Botox / other injections ☐ Dermatitis ☐ Laser Resurfacing

☐ Skin Cancer ☐ Keloid Scarring ☐ Chemical Peels ☐ Claustrophobia ☐ Hepatitis

☐ MRSA ☐ Heart Condition/High Blood Pressure ☐ Permanent Cosmetics

☐ Recent Chemical Peel, Laser Resurfacing? When? _____

☐ Epilepsy or Diabietes? *(If yes, you will be treated only with a doctor's release)*

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

☐ Skin Care Products ☐ Cosmetics ☐ Asprin ☐ Iodine ☐ Seawood

☐ Other? Please list:

Have you recently been exposed to the sun or had a sun burn? ☐ Yes ☐ No

Do you use sunscreen/sunblock? ☐ Yes ☐ No

Do you sunbathe or use tanning beds? ☐ Yes ☐ No

Do you have or have you ever had acne? ☐ Yes ☐ No

Are you using or have you ever used any medications for acne? ☐ Yes ☐ No

Name of medication:

Have you seen a dermatologist in the past year? ☐ Yes ☐ No ☐ Currently

If yes, list doctor's name and reason for visit:

FEMALE CLIENTS

Are you on hormone-replacement therapy? ☐ Yes ☐ No

Are you presently taking birth control pills? ☐ Yes ☐ No

Are you pregnant or planning to be? ☐ Yes ☐ No

ALL CLIENTS

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you presently under a doctor's care ☐ Yes ☐ No

What medications do you take on a regular basis?

Have you ever had herpes (cold sores)? ☐ Yes ☐ No

Have you ever been treated with Zovirax or any medication for herpes? ☐ Yes ☐ No

What skin-care products are you currently using?

Is there any other information we should know before begining your treatment?

INFORMED CONSENT

I understand, have read and completed this questionnaire truthfully. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Signature: Date:

Aesthetician Signature: Date: