Name: _____

Date: _____

Facial Consent

Have you had cosmetic surgery/non-surgical procedure? Yes___ No___

When?_____ Doctor _____ What Type?_____

Please check any Skin conditions you are experiencing:

Hands/Face: Sun Spots___ Freckles___ **Lip Area:** Fine Lines___ Wrinkles___

Face/Neck: Fine lines___ Wrinkles___ **Eye Area:** Fine lines___ Wrinkles___ Dark Circles___

Face/Chest/Back: Acne Scars___ Acne Breakout___ Blackheads___ Whiteheads___ Clogged Pores___ Excess Facial Hair___ Dry Chapped Lips___

In-Grown Hair: Face___ Bikini Line___ Underarms___ Other_____

Skin Type: Dry___ Oily___ Aging___ Combo:____ Rosacea___ Sensitive___ Other:____

What are your specific goals for today: _____

_____

Please list facial products used:

Cleanser _____ Toner_____ Moisturizer_____

Night Cream_____ Make up_____ Other _____

Check any health conditions which you are now experiencing:

HIV___ Diabetes___ High/Low Blood Pressure___ Cancer___ Pregnant___ Thyroid___ Eczema/Psoriasis___

Hepatitis____ Migraine____ Herpes Simplex___ Active Sores____

Check which applies to your daily routine:

Acutane/Creams___ Retin A___ Retinol___ Contact lens___ HRT____ Bar Soap___

Metal Implants___ Birth Control____

Daily water intake: _____Glasses **Smoking**: Packs/day____ **Alcohol intake**:____/week Type?_____

List any drug/food allergies or reactions: _____

List all medications/supplements you are currently taking: _____

_____

Your Signature below indicates you have provided accurate information. Your therapist uses all natural edible organic food products and essential oils in their facials. It is mandatory that you disclose any food allergies prior to the treatment. We cannot be held responsible for any preventable reactions.

Client Signature: _____ **Date**: _____

Client Printed Name: _____