Touché

Medical Spa & Skin Care

Look & feel your best with experienced, leading-edge care & pampering.

Esthetic Client Consultation Form

Name: ______________________________ Therapist: ______________________________
Address: ____
Tel#: ______________________________ Other Tel#: ______________________________
Email Address: __________________________ Emergency Tel#: _________________________
______ Birthday: Month _____ Day _____ How did you hear about us? ______________________
Anniversary: Month _____ Day _____
What skin care concern(s) do you have pertaining to your face or body?
____

Check ALL that apply:

__ Ingrown Hairs	__ Cancer
__ Thyroid	__ Skin Cancer
__ Hysterectomy	__ Taking Oral Contraceptive
__ Hormone Imbalance	__ Epilepsy
__ Heart Problems	__ Use SPF 15 or Higher
__ Low Blood Pressure	__ Contact Lens User
__ High Blood Pressure	__ Frequent Headaches
__ Any Metal Implants	__ Migraines
__ Diabetes	__ Varicose Veins
__ Hypoglycemic	__ Tobacco User
__ Restless Leg Syndrome	__ Caffeine: Daily __ Wkly __
__ Bleeding Disorders	__ Open Sores
__ Immune Disorders	__ Herpes Simplex

__ Undergone Dermatology Treatment (List All)
____
____

__ Surgery in last 12 months (List All)
____
____

List ALL medication(s) you are currently taking:
____
____
____

__ Currently using other topical medication (List All) ________________________________
___

__ Sun Sensitive
__ Allergic to: __Aspirin __ Salicylic Acid __ Salt/Sea Salt __ Iodine
__ Currently taking Isotretinoin (Accutane)
__ Currently taking Retinols (Vitamin A Derivative)
__ Currently using topical AHA/BHA?

__ Food & other allergies (List All)
____
____

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Check ALL that apply:
What facial skin care products are you currently using?
__ Soap
__ Cleanser
__ Toner/Astringent
__ Masque
__ Moisturizer
__ Exfoliant/Acid/Scrub
__ Topical Vitamin
__ Topical Serum
__ Eye Product
__ Other Product(s) ____
Any allergic reaction(s) to the above products? __ Yes __ No
List reaction(s):
____
____
Do you experience an oily shine during the day? __ Yes __ No __ Occasionally
Do you experience skin breakouts? __ Yes __ No __ Occasionally
How many ounces of plain water do you consume daily? _____
How many alcoholic beverages do you consume weekly? _____
Do you ever experience these conditions on your skin __ Flakiness __ Tightness __ Dryness
What SPF sunscreen do you use on your <u>face</u>? _____
What SPF sunscreen do you use on your <u>body</u>? _____
Are you currently sunbathing and/or using a tanning bed? __ Yes __ No
When exposed to the sun do you:
Circle one: burn always burn sometimes burn rarely never burn

<u>FEMALE Clients Only</u>
Are you taking oral contraception? __ Yes __ No
Are you pregnant or trying to become pregnant? __ Yes __No
Are you lactating? __ Yes __ No

<u>MALE Clients Only</u>
What is your current shaving system? __ Electric Shave __ Wet Shave
Do you experience irritation from shaving? __ Yes __ No
Do you experience ingrown hairs? __ Yes __ No

I have stated all medical conditions that I am aware of and will update my therapist of <u>any changes</u> in my health status.

Signature: ____ Date: ________________

1905 Skibo Road • Fayetteville, NC 28314 (Across from Cross Creek Mall in the Rapha Plaza) (910) 864-4357 • Fax: (910) 221-0099