Facial Consent Form

THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A FACIAL.

General & Medical Information

List any medications, supplements that you are currently taking:

____

What temperature of water do you cleanse with?

____

Do you have any specific skin care problems / allergies pertaining to your face or body?

____

What skin care products do you currently use?

____

Have you ever had chemical peel, laser, microdermabrasion, or any skin resurfacing treatments? If yes, when was your last treatment?

____

Do you use Retin A, Renova, or Adapalene?

____

Do you use acne medication? What kind?

____

Do you burn easily? _______ Do you experience an oily shine during the day? _______

Do you wear SPF? ______ Are you currently having your menstrual period? _______

Do you experience breakouts? ______ Are you taking oral contraceptives? _______

What are your skin care goals?

____

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated.

Client Signature _________________________ Date ______________________

NAME: _________________________________ PHONE: ________________________