Client Consultation

Date _____

Name _____ Phone _____

Address _____

Email Address _____

Occupation _____ Does your job require that you work out doors? ☐ Yes ☐ No

Referred By _____

What would you like to achieve from your treatment today? _____

_____

Your Skin Care

Have you ever had a facial treatment before? ☐ Yes ☐ No

When? _____

Have you ever had a body spa treatment before? ☐ Yes ☐ No

Massage Body Scrub

Other: _____

Which of the following best describes your skin type? (Please circle one type number)

I.	Creamy complexion	Always burns easily, never tans
II.	Light complexion	Always burns, tans slightly
III.	Light/matte complexion	Burns moderately, tans gradually
IV.	Matte complexion	Seldom burns, always tans well
V.	Brown complexion	Rarely burns, deep tan
VI.	Black complexion	Never burns, deeply pigmented

Do you have any special skin problems or concerns pertaining to your face or body? ☐ Yes ☐ No

Specify _____

Have you ever had chemical peels, laser or microdermabrasion? ☐ Yes ☐ No

In the last month? ☐ Yes ☐ No

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? ☐ Yes ☐ No

Describe: _____

Have you used any of these products in the last 3 months? ☐ Yes ☐ No

Have you used an acne medication? ☐ Yes ☐ No

When? _____ Which drug? _____

What skin care products are you currently using?

Soap _____
Toner _____
Mask _____
Eye Product _____
Cleanser _____
Day Moisturizer _____
Exfoliator _____
Scrubs _____

Shower Gels _____
Body Lotions _____
Sunscreen _____
SPF _____
Night Moisturizer/Cream _____
Other _____
Makeup Products _____
_____

Have you recently used any self-tanning lotions, cream or treatments? If yes, please specify.

_____

Have you used any of the following hair removal methods in the past six weeks? (Please Circle all that apply)

Shaving Waxing Electrolysis Tweezing Stringing Depilatories

What areas of concern do you have regarding your skin? (Please circle all that apply)

Breakouts/acne
Blackheads/whiteheads
Rosacea
Redness/ruddiness
Sun damage
Dull/dry skin
Dehydrated
Uneven skin tone
Excessive oil/shine
Broken capillaries
Sun spot/liver spot/brown spot
Wrinkles/fine lines
Flaky skin
Other_____

What are the areas of concern regarding your eyes? (Please circle all that apply)

Dehydrated
Wrinkles
Puffiness
Dark circles
Other_____

Have you ever had an allergic reaction? ☐ Yes ☐ No If yes, please explain.

_____

_____

What SPF do you use on your face? _____

How often and when do you use it? _____

Have you had any recent tanning bed or sun exposure that changed the color of your skin? ☐ Yes ☐ No

If yes, please specify _____

_____

☐ Yes ☐ No

Have you experienced Botox, Restylane or Collagen injections?

If so, please specify _____

_____

Female Clients only

Are you taking oral contraceptives? ☐ Yes ☐ No

Specify: _____

Any recent changes to or from your contraceptive treatment? ☐ Yes ☐ No

If so, what and when: _____

Are you pregnant or trying to become pregnant?

Are you lactating? ☐ Yes ☐ No

Any menopause problems? ☐ Yes ☐ No

Specify: _____

Are you undergoing any hormone replacement therapy?

Specify: _____

Male clients only

What is your current shaving system? ☐ Wet Shave ☐ Electric

Do you experience irritation from shaving? ☐ Yes ☐ No Ingrown Hairs? ☐ Yes ☐ No

Please use this space to complete answers where space was sufficient. (Please include the number of the question.)

_____

_____

_____

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information and 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 EVIASPA and/or skincare professional from liability and assume full responsibility thereof.

Client signature _____ Date _____