



Please print.

TODAY'S DATE: ____ | ____ | ____

Name Date of birth Age Female Male
 Address
 City State Zip code
 H M W Phone Occupation
 Referred by Phone
 Emergency contact Phone
 Physician Health insurance carrier

Is this your first facial? Yes No
 What is your main goal for your skin?
 Are you in a dermatologist's care for a skin condition? Yes No
 If yes, please explain:
 Are you using or have you used Accutane, Azlex, Differin, Renova, Retin-A, Tazarac, or glycolic or alpha hydroxy acids? Yes No
 If yes, please list:
 When, and for how long?
 Have you had Botox or fillers within the past week? Yes No
 Are you pregnant? Yes No
 Are you on birth control? Yes No
 If yes, what type?

Are you presently taking any medications? Yes No
 If yes, please list:
 Are you taking skin thinners or blood thinners? Yes No
 Do you wear contact lenses? Yes No
 Do you smoke? Yes No
 Do you have any allergies to cosmetics, food, or drugs? Yes No
 If yes, please list:
 Do you have or have you had skin cancer? Yes No
 If yes, what kind?
 Do you often experience stress? Yes No
 What skin care products are you currently using?
 Please list:

Please check any of the medical issues listed below that you have currently or have been affected by in the past:

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches [chronic] | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Metal implants | <input type="checkbox"/> Skin disease |

Please explain issues checked, or any others not listed:

Any physical limitations? Please explain:

I understand that the services offered are not a substitute for medical care. Any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the esthetician in providing the best possible service. All information is kept completely confidential.

CANCELLATIONS: Spa Caladae Esthetique Studio requires minimum 24 hours notice for cancellations of any scheduled appointments and minimum 48 hours notice for group appointments to avoid charges. If required notice is not given within the timeframe specified, 50% of cost of service scheduled will be charged to the client. Clients who do not show at all or do not give required cancellation notice at all will be charged 100% of cost of service scheduled. Late arrivals may result in reduced or canceled service.

CONSENT TO TREATMENT OF A MINOR [individuals under the age of 18]: By providing signature below, parents and/or guardians of a minor authorize Spa Caladae Esthetique Studio personnel to administer service treatments to their child/dependent as they deem necessary.

Client signature Date

Parent/guardian signature Date

Esthetician signature Date