Client Consultation Form

Full Name: _____ Date: _____

DOB: _____ Phone: _____ Email: _____

Address: _____ City: _____

State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Relation: _____

Skin Type:

- ☐ Normal
- ☐ Dry
- ☐ Oily/Acneic
- ☐ Combination

Skin Concerns:

- ☐ Dry/Flakiness
- ☐ Dull/Lackluster
- ☐ Red/Sensitive
- ☐ Oily/Shine
- ☐ Enlarged Pores
- ☐ Acne/Breakouts
- ☐ Black/Whiteheads
- ☐ Age/Liver Spots
- ☐ Uneven Skin tone
- ☐ Sun Damage
- ☐ Fine Lines
- ☐ Wrinkles

1. Have you ever been or are you currently under the care of a dermatologist?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

2. Have you ever or are you currently using:

- ☐ Accutane
- ☐ Renova
- ☐ Retin-A
- ☐ Topical Antibiotics

Other: _____

3. Have you received in the last 6 months, Botox, Fillers, or any other kind of injection?

- ☐ Yes
- ☐ No

4. Do you have allergies to animals, food, cosmetics and etc.?

- ☐ Yes
- ☐ No

If yes, please explain:

_____

5. Are you currently taking any medications or vitamins regularly?

☐ Yes ☐ No

If yes, please explain:

_____

6. What, if any, skin care products are you using at home?

☐ Soap and Water ☐ Cleanser ☐ Toner ☐ Serum

☐ Eye Cream ☐ Moisturizer ☐ SPF

Other: _____

7. Do you have any personal or family history of skin cancer?

☐ Yes ☐ No

If yes, please explain:

_____

8. If female, are you trying to get pregnant, pregnant and or breastfeeding?

☐ Yes ☐ No

9. Have you experienced any of the following, past or present?

Acne	☐ Yes	☐ No
Arthritis or Bursitis	☐ Yes	☐ No
Blood Pressure	☐ High	☐ Low
Breast Implants	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Cholesterol	☐ High	☐ Low
Claustrophobic	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Eczema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Heart Disease/Condition	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Herpes Simplex 1 or 2	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Menopausal	☐ Yes	☐ No
Metal Implants	☐ Yes	☐ No
Pace Maker	☐ Yes	☐ No
Thyroid Issues	☐ Yes	☐ No
Varicose Veins	☐ Yes	☐ No

Are you a smoker?	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No

10. Do you have any sensitivity to or dislike for any of the following? Check all that apply.

☐ Passionfruit	☐ Raspberry	☐ Peach	☐ Coconut
☐ Lemon	☐ Pomegranate	☐ Cherry	☐ Pumpkin
☐ Orange	☐ Blueberry	☐ Cucumber	☐ Citrus

Please list any other scents and/or aromas that are not included above:

_____
__

I do fully understand all the questions above and have answered them all correctly and honestly. I understand that the services offered are not a substitute for medical care. I understand that the skin care professional will completely inform me of what to expect during treatment and will recommend adjustments to my regimen if deemed necessary. I am also aware that individual results are dependent upon age, skin condition and lifestyle.

I have read and understand all the foregoing information.
Client Signature: _____ Date: _____

Dermaplaning Consent

I, _____ give my consent for the following procedure:

Dermaplaning to be performed by Amanda (Mo) Lynch, a licensed skin care professional

I understand there are contraindications to this treatment, including but not limited to, diabetes, cancer, active acne, bleeding disorder and the inability for blood to coagulate following injury. Certain medications including blood thinners, higher dosages of Aspirin and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I have made my service provider aware of me taking any of the above medications and/or experiencing any of the above conditions.

I understand this treatment involves the use of a surgical blade to remove dirt, debris, dead skin cells and vellus hair. As with the use of any sharp instrument, there is a possibly to nick or cut the skin during this treatment. While every precaution is taken, I understand the risks and consent to receive this treatment.

Print Name: _____

Client Signature: _____

Date: _____