

**Client Skin Analysis/Consultation Form**

**Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Phone numbers:**      **Cell:** \_\_\_\_\_      **Home:** \_\_\_\_\_

**Emergency Contact: Name:** \_\_\_\_\_      **Phone:** \_\_\_\_\_

How did you hear about our services? \_\_\_\_\_

**Desired service:**

**Esthetic services:**     Facial     Acne treatment     Waxing     Other:

**Hair Removal to** \_\_\_\_\_

**Photofacial**

**Treatment of veins**

**Treatment of fine lines and wrinkles**     **Botox**     **Facial fillers**

**Latisse eyelash lengthener**

**Other:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_  
\_\_\_\_\_

**Present Medications, including over the counter medications /**

**Vitamins:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History:**

**Yes/ No** Under the care of a physician, dermatologist, or other medical professional within the past year, if yes, please explain \_\_\_\_\_

**Yes/ No** Currently pregnant or planning on getting pregnant in the next 6 months

**Yes/ No** Active or history of herpes, cold sores, or fever blisters    Last outbreak: \_\_\_\_\_

**Yes/ No** History of keloids/hypertrophic scars (thick or raised scars from cuts or burns)

**Yes/ No** History of diabetes -controlled/uncontrolled

**Yes/ No** History of coronary artery disease

**Yes/ No** History of high blood pressure

**Yes/ No** History of seizure disorder or migraines

**Yes/ No** History of neuromuscular disorders

**Yes/ No** History of skin cancer

**Yes/ No** History of varicose veins

**Yes/ No** History of Lupus or Porphyria

**Yes/ No** Currently menopausal

**Yes/ No** History of hormone imbalance

**Yes/ No** Metal bone pins or plates

**Yes/ No** History of blood clotting abnormalities  
**Yes/ No** Any chronic skin conditions  
**Yes/ No** Use of Coumadin, Lovenox (blood thinners)  
**Yes/ No** Recent surgery, including plastic surgery:

\_\_\_\_\_  
**Yes/ No** Piercing, tattoos, or permanent cosmetics

\_\_\_\_\_  
**Yes/ No** Currently smoke

Has a physician discussed concerns about raising your body temperature **Yes/ No**

Are you currently under care of another health care provider for any reason? **Yes/No** If yes, please list below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OVER →**

**Previous and recent treatment history:**

- |  |   |
|--|---|
| <input type="checkbox"/> Electrolysis                    | <input type="checkbox"/> Facial peels         |
| <input type="checkbox"/> Mechanical epilation (plucking) | <input type="checkbox"/> Laser (type)_____    |
| <input type="checkbox"/> Waxing                          | <input type="checkbox"/> Botox/dermal fillers |
| <input type="checkbox"/> Microdermabrasion               |   |

**Skin Analysis Questions:**

What daily facial cleansers/skin products used? Rx or OTC

\_\_\_\_\_  
\_\_\_\_\_

Have you had any reactions to skin care products? **Yes / No**  
If yes, please explain what the product was and your reaction.

\_\_\_\_\_  
\_\_\_\_\_

Do you use any acne medications? Please include both topical and oral medications:

\_\_\_\_\_  
\_\_\_\_\_

Have you used Isotretinoin (*Accutane*) within 6 Mos? (laser treatments contraindicated) **Yes / No**

Are you currently using Retinoic acid (*Retin A*); Alpha Hydroxy, or Glycolic Acid peels? **Yes / No**  
If yes, d/c 2 days before and after treatment

Do you follow a restricted diet? **Yes / No** If so, explain

\_\_\_\_\_

Do you follow a regular exercise program? **Yes / No**

Do you use a tanning bed? **Yes / No**

What is your stress level: **High**                      **Medium**      **Low**

List your daily consumption of: Water\_\_\_\_\_ Caffeine\_\_\_\_\_ Alcohol \_\_\_\_\_

Any menopause problems: **Yes / No** If yes, specify

\_\_\_\_\_

If you could change anything about your skin what would you change?

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*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 or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the healthcare provider/esthetician of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution, healthcare provider and/or skin care professional from liability and assume full responsibility thereof.*

**Client Signature:** \_\_\_\_\_

**Date:**

**Belleza Financial Policies and Procedures:**

- ❖ **Initial consultation is required prior to any treatments or procedures.**
- ❖ **Payment arrangements: Payment in full is required at the time of each treatment session. We accept cash, check, or VISA and Mastercard.**
- ❖ **If you need to cancel or reschedule your appointment with us, please notify us at least 24 hours prior to your appointment time. Due to our extensive waiting list, patients who do not give us the required notice will be charged 50% of the services that were scheduled. Also, if you arrive late for your appointment, we cannot guarantee that you will be seen.**