HANDS-ON WELLNESS FACIAL CONSULTATION FORM

Name_____ Date _____

Address_____

City_____ Post Code_____

Phone_____

Email_____

Have you had a facial before? Yes_____ No_____

What are your specific skin care concerns? Dry/Flaky_____ Age/Sun spots_____ Fine Lines_____

Excess oil_____ Redness/Sensitivity_____ Blackheads_____ Breakouts_____

None_____Other_____

What skin care products are you currently using at home? Cleanser_____ Toner_____

Exfoliant/Scrub_____ Serum_____ Day Moisturizer_____ Night Moisturizer_____

Eye Cream_____ Brand(s):

_____

Are you pregnant, lactating or plan on becoming pregnant soon? No_____ Yes_____

List all know allergies (food, products, ingredients, medication, etc.)

_____

Have you ever had a reaction to skin care products or ingredients? No_____ Yes_____

Explain_____

Are you using any prescribed exfoliants? (Retin-A, Diferen, Renova etc.) No_____ Yes_____

Are you under the care of a doctor for an auto immune disorder? No_____ Yes_____

How many ounces of water do you drink daily? _____

On average, how many hours of sleep do you get each night? _____

On a scale of 1-10 what is your current stress level? _____

Do you take supplements/vitamins? Yes_____ No_____

I understand that redness, sensitivity, peeling or other reactions may occur from facial treatments. If I experience any 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 Estheticians are not qualified to diagnose, prescribe or treat any disease or illness and that a facial should not be a replacement for medical treatment. The treatments I receive here are voluntary and I release Hands-on Wellness from liability and assume full responsibility thereof.

Signature_____

Date_____