Skincare Treatments – Client Information and Consent

Name
Address
City, State, Zip
Phone, E-mail

How did you hear about us?
Employer, Occupation

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

Skin Care History

Have you ever had a facial treatment or chemical peel before? _____ Yes _____ No
Which of the following most closely describes your skin type?

<table>
<thead>
<tr>
<th>No.</th>
<th>Skin Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Creamy Complexion</td>
<td>Always burns easily, never tans</td>
</tr>
<tr>
<td>II</td>
<td>Light Complexion</td>
<td>Always burns, may tan slightly</td>
</tr>
<tr>
<td>III</td>
<td>Light / Matte Complexion</td>
<td>Burns moderately, tans gradually</td>
</tr>
<tr>
<td>IV</td>
<td>Matte Complexion</td>
<td>Seldom burns, always tans well</td>
</tr>
<tr>
<td>V</td>
<td>Brown Complexion</td>
<td>Rarely burns, deep tan</td>
</tr>
<tr>
<td>VI</td>
<td>Black Complexion</td>
<td>Never burns, deeply pigmented</td>
</tr>
</tbody>
</table>

Do you have any special skin problems or concerns?

Do you use Retin-A, Renova, or Retinol/vitamin A derivative products? _____ Yes _____ No

Have you used any alpha-hydroxy acid or glycolic acid products in the last 48 hours? _____ Yes _____ No

Are you currently taking Accutane or have you taken it in the past? _____ Yes _____ No How long ago?

Have you used other acne medication? _____ Yes _____ No If yes, which one?

Are you exposed to the sun on a daily basis or do you use a tanning bed? _____ Yes _____ No

What skin care products are you currently using? Please list the brand if known:

Cleanser _______________________________ Toner _______________________________

Mask _______________________________ Moisturizer _______________________________

Eye Product _______________________________ SPF _______________________________

Exfoliation / Scrubs _______________________________ Night Cream _______________________________

Treatment / Acne product _______________________________ Makeup Brand _______________________________
Please circle any areas of concern you have regarding your skin:

- Breakouts / Acne
- Blackheads / Whiteheads
- Excessive Oil / Shine
- Rosacea
- Broken Capillaries
- Redness / Rudliness
- Sun spot / Brown spots
- Uneven Skin Tone
- Sun Damage
- Wrinkles / Fine Lines
- Dull / Dry Skin
- Flaky Skin
- Dehydrated Skin
- Sensitive Skin

Eyes:
- Dark Circles
- Puffiness
- Fine lines

Please circle if you have ever had an allergic reaction to any of the following:

- Cosmetics
- Medicine
- Food
- Animals
- Sunscreens
- Pollen
- AHAs
- Fragrance
- Shellfish
- Latex
- Collagen
- Other: ___________________________________________________________________________________________________

Have you ever had Botox, Restylane, or other injections? _________________________________________________________________________
_____________________________________________________________________________________________________

Ladies only:
Are you taking hormonal contraceptives? _____ Yes _____ No

Are you pregnant or trying to become pregnant? _____ Yes _____ No Are you nursing? _____ Yes _____ No

Experiencing any menopause problems? ____________________________________________________________________________________

Are you undergoing any hormone replacement therapy or cancer treatments? ____________________________________________________________________________________________________

I understand this consent form and have answered each question truthfully. I understand that withholding information from my skin care therapist may result in contraindications or skin irritation from treatments received. The skin care treatments I receive at Belle Waxing and Skincare are voluntary and I release Belle Waxing and Skincare from liability and assume full responsibility thereof.

Signature ___________________________ Date ___________________