



# FACIAL TREATMENT

## *Consultation Form*

### CLIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male  NB  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Your Occupation: \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Would you like to be added to our email list for news and exclusive offers? Yes  No

### MEDICAL HISTORY

*Do you have or have you had any of the following conditions? If yes, please select them:*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne            | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Low blood pressure     |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Lupus                  |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Metal bone pins/plates |
| <input type="checkbox"/> Blood disorder  | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Phlebitis, blood clots |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Hyper pigmentation  | <input type="checkbox"/> Seizure disorder       |
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hypo pigmentation   | <input type="checkbox"/> Skin disease/lesions   |
| <input type="checkbox"/> Eczema          | <input type="checkbox"/> Hysterectomy        | <input type="checkbox"/> Seborrhea              |
| <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Immune disorders    | <input type="checkbox"/> Thyroid condition      |
| <input type="checkbox"/> Fever blisters  | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Varicose veins         |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Keloid scarring     | <input type="checkbox"/> Warts                  |

Any other condition: \_\_\_\_\_

Any known allergies?  No  Yes: \_\_\_\_\_

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

---

Any recent surgery, including plastic surgery?  No  Yes, explain: \_\_\_\_\_

♀ Are you pregnant or trying to become pregnant?  No  Yes

Have you ever had a facial treatment before?  No  Yes

If yes, please explain: \_\_\_\_\_

What would you like to achieve from your treatment today?

---

**SKIN CARE**

*Please Check Current Products You Use:*

- |   |                                      |                                       |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Eye Make-Up Remover    | <input type="checkbox"/> Eye Cream   | <input type="checkbox"/> Mask         |
| <input type="checkbox"/> Cleansing Cream        | <input type="checkbox"/> Day Cream   | <input type="checkbox"/> Facial Scrub |
| <input type="checkbox"/> Facial Soap            | <input type="checkbox"/> Night Cream | <input type="checkbox"/> Exfoliants   |
| <input type="checkbox"/> Skin Toner/ Astringent | <input type="checkbox"/> Neck lotion | <input type="checkbox"/> Body Lotion  |
| <input type="checkbox"/> Body Soap              | <input type="checkbox"/> Hand cream  | <input type="checkbox"/> Body Scrub   |

**SKIN HISTORY**

- What is your skin type?  Normal  Oily  Dry  Combo  Unsure
- Your exposure to the sun?  Never  Light  Moderate  Excessive
- What type of foundation do you wear?  Liquid  Cream  Powder  None
- How does your skin heal?  Fast  Slow  Scars  Pigments
- Do you get bruises easily?  No  Yes

**SKIN CONCERNS**

- |   |  |                                    |  |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Acne               | <input type="checkbox"/> Dryness/Dull Skin   | <input type="checkbox"/> Milia     | <input type="checkbox"/> Sensitivity   |
| <input type="checkbox"/> Blackheads         | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Sun Damage    |
| <input type="checkbox"/> Broken Capillaries | <input type="checkbox"/> Fine lines/Wrinkles | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thin Skin     |
| <input type="checkbox"/> Comedones          | <input type="checkbox"/> Hyper pigmentation  | <input type="checkbox"/> Redness   | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Cherry Angioma     | <input type="checkbox"/> Hypo pigmentation   | <input type="checkbox"/> Rosacea   | <input type="checkbox"/> Other:        |
| <input type="checkbox"/> Discoloration      | <input type="checkbox"/> Keloids             | <input type="checkbox"/> Scarring  | _____                                  |

Have you ever used acne medication?  No  Yes

If yes, when? \_\_\_\_\_ Which drug? \_\_\_\_\_

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products?  No  Yes, please describe: \_\_\_\_\_

Have you received Botox, Restylane, or Collagen injections in the last 6 months?

No  Yes, please describe: \_\_\_\_\_

*By signing below, you agree to the following:*

*I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health history.*

\_\_\_\_\_  
*Client Name (printed) :*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Client Name (signature) :*

\_\_\_\_\_  
*Date*

**WE LOOK FORWARD TO WORKING WITH YOU!**



## *Client Consent Form*

I hereby consent to and authorize Spa Therapy to perform the following procedure: \_\_\_\_\_

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by:

\_\_\_\_\_

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand there may be post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

*I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.*

\_\_\_\_\_  
*Client Name (printed)*

\_\_\_\_\_  
*Client Name (signature)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Esthetician (signature)*

\_\_\_\_\_  
*Date*

SPA THERAPY

www.spatherapydothan.com // 334-446-3940



## *Photo & Video Release Form*

I, \_\_\_\_\_ hereby grant and authorize Spa Therapy the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and /or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph or recording.

I understand and agree that these materials shall become the property of \_\_\_\_\_ Spa Therapy \_\_\_\_\_ and will not be returned.

I hereby hold harmless and release \_\_\_\_\_ Spa Therapy \_\_\_\_\_ from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

*By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.*

\_\_\_\_\_  
*Client Name (printed) :*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Client Name (signature) :*

\_\_\_\_\_  
*Date*



## *Cancellation Policy*

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you may be asked to pay a deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment. We understand things come up but this allows us to fill your spot so we do not lose income. However, providing less than 24 hours' notice will require you to pay a fee of 50% of the appointment amount. If you cancel your appointment within 2 hours or less of your appointment time or fail to show, it will result in a charge of 100% of the treatment booked.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged 100% of your scheduled service price which must be paid immediately with the card on file before scheduling future appointments.

We are happy to answer any questions regarding this cancellation policy.

*I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by it's terms. I agree to pay the cancellation fee in the event of a missed appointment.*

---

Client Name (printed) :

---

Date

---

Client Name (signature) :

---

Date



# FACIAL TREATMENT

## *Skin Analysis Form*

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male  NB  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### SKIN ANALYSIS

#### *Skin type:*

Normal  Oily  Dry  Sensitive  
 Combination

#### *Pores:*

Fine  Dilated  Comedones  Milia

#### *Moisture content:*

Excellent  Good  Fair  Poor

#### *Elasticity:*

Excellent  Good  Fair  Poor

#### *Acne:*

No  
 I  II  III  IV

#### *Skin sensitivity:*

Normal  Sensitive  Hyper sensitive

#### *Fine lines (Glogau scale):*

I - None  II - Wrinkles in motion  
 III - Wrinkles at rest  IV - Mostly wrinkles

Known allergies:

\_\_\_\_\_

Medications:

\_\_\_\_\_

Previous treatments:

\_\_\_\_\_

Life style:

Active  Sedentary

### NOTES

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

