



# FACIAL TREATMENT CONSULTATION ANALYSIS

DATE \_\_\_\_\_ SKIN TECHNICIAN \_\_\_\_\_

CLIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS 1 \_\_\_\_\_ ADDRESS 2 \_\_\_\_\_

AGE \_\_\_\_\_ SEX:  F  M OCCUPATION \_\_\_\_\_

### PLEASE ANSWER HONESTLY!!

The following information provides the skin technician with answers regarding your general health and lifestyle. It also enables a more accurate analysis plus specific treatment recommendations for you needs, along with identifying contributing factors to existing conditions.

Check all conditions that apply.

#### GENERAL HEALTH

- |   |                                    |  |   |
|---|------------------------------------|--|---|
| <input type="checkbox"/> Heart condition  | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Glandular swelling  | <input type="checkbox"/> Metal implants |
| <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Swollen joints      | <input type="checkbox"/> Hypertension   |
| <input type="checkbox"/> Recent operation | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Allergies      |
| <input type="checkbox"/> Contact lenses   | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pregnancy      |

#### Do you take prescription medication for:

- Diabetes
- Thyroid condition
- Other (describe condition)

#### Do you take:

- Tranquilizers
- Diet pills
- birth control
- Other (describe)

#### LIFESTYLE (check all that apply)

- |                                  |   |   |                                   |
|----------------------------------|---|---|-----------------------------------|
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Tea            | <input type="checkbox"/> Sun exposure (tanning) | <input type="checkbox"/> Exercise |
| <input type="checkbox"/> Coffee  | <input type="checkbox"/> Alcohol intake | <input type="checkbox"/> Salt                   |                                   |

#### NUTRITION

- Fruit     meat     Starch     Dairy     water     Vegetables



# FACIAL TREATMENT SKIN EVALUATION

DATE \_\_\_\_\_ SKIN TECHNICIAN \_\_\_\_\_

CLIENT NAME \_\_\_\_\_

## SKIN COLOR

- Dark                       Olive                       Yellow                       Red  
 Healthy                       Unhealthy

## SKIN TYPE

- Sensitive                       Dry                       Mature                       couperone  
 Oily                       Acne                       normal/combination

## EXISTING CONDITIONS

- Flaking                       Pustule acne                       Blackheads                       Enlarged pores  
 Peeling                       Whiteheads                       Blemishes                       Broken capillaries

## FACIAL HAIR

- Normal                       Hyper                       Other \_\_\_\_\_

OBSERVATIONS \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## SKIN TREATMENT SCHEDULE (FOR SPA TECHNICIAN ONLY!!)

Date/ Initials	Treatment	Cleanser	Toner	Masque	Nourish	Moisture	Other	Prices



# MEDICAL HISTORY

Are you currently under the care of a physician of other medical practitioner or counselor?  Y  N  
If yes, for what condition? \_\_\_\_\_

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There are some medical conditions that require the Massage Therapist consult/receive permission from your Health care Practitioner before administering a massage. Should the need arise, may we have your permission to contact your Medical Provider?    Y    N

### GENERAL HEALTH (check all that apply)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Heart disease  | <input type="checkbox"/> Arteriosclerosis    | <input type="checkbox"/> Varicose veins     |
| <input type="checkbox"/> Phlebitis            | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Fluid retention     | <input type="checkbox"/> Urinary frequency  |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Fibrosis       | <input type="checkbox"/> Fibromyalgia        | <input type="checkbox"/> Fractures          |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Herniated disc      | <input type="checkbox"/> Artificial limbs   |
| <input type="checkbox"/> Metal pins           | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Skin sensitivity   |
| <input type="checkbox"/> HIV+                 | <input type="checkbox"/> Hepatitis A    | <input type="checkbox"/> Hepatitis B         | <input type="checkbox"/> Hepatitis C        |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Pregnancy      | <input type="checkbox"/> Inner Ear problems  | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Implants             | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Automobile Accident | <input type="checkbox"/> Easy Bruising      |
| <input type="checkbox"/> Weight gain          | <input type="checkbox"/> Weight Loss    | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Pace maker           | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Organ Transplant    |   |

Explain any medical conditions checked above: \_\_\_\_\_

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## ADDITIONAL PERSONAL INFORMATION

DATE \_\_\_\_\_

CLIENT NAME \_\_\_\_\_

Date of Birth \_\_\_\_\_

Occupation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Mobile \_\_\_\_\_

Recent personal Loss?  Yes  No Check all that apply:

Death  Divorce  Separation  Relationship  Job

Comments

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History of Abuse?  Yes  No

Comments

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\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date