

The Spa & Wellness Center

Client Facial Form

Name: _____ DOB: ___ / ___ / ___

Address: _____

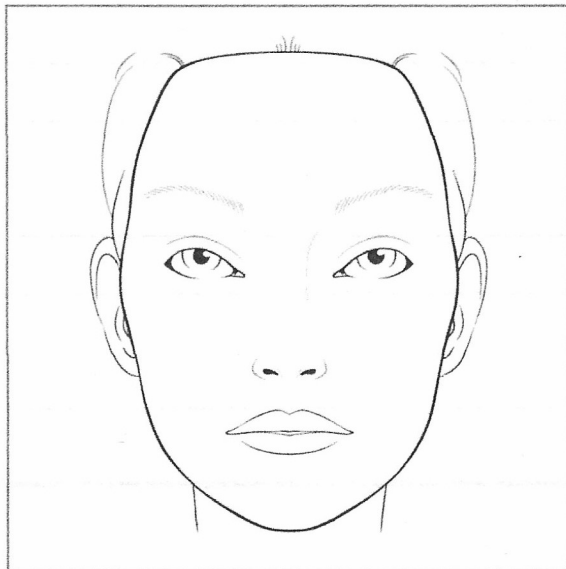
City: _____ State: _____ Zip: _____ Phone: (____) _____

Referred by: _____

Occupation: _____

Skin Care

Please circle the areas of concern on the facial diagram.



In a few words, describe your skin.

If you could change three things about your skin, what would they be?

Please take a moment to answer the following questions.

1. Is this your first facial? Yes No
2. What brings you in today?
3. Do you wear contacts? Yes No
4. Are you pregnant? Yes No
5. Do you have any allergies to cosmetics, foods or drugs? Yes No

If so, please list. _____

6. Have you had skin cancer Yes No If so, when?

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7. Are you now using Accutane or have you ever in the past? Yes No

If so, please provide the date of when last taken. _____

8. Are you presently taking any medications? (Oral or topical) Yes No

If so, please list. _____

9. Have you had any recent cosmetic procedures on or around the face/neck? Yes No

If so, please provide the date and service. _____

10. Within the past year, have you had any surgeries? Yes No

If so, please list. _____

11. Have you had waxing within the past week? Yes No

If so, please provide the date and the area waxed. _____

12. Have you had a chemical peel before? Yes No

If so, please list when last received. _____

It is my choice to receive esthetic treatments. I understand that any information given is strictly confidential and will be used for no purpose other than to assist the therapist/esthetician in providing a suitable treatment which would take into consideration to my specific requirements. I also understand that failure to disclose information could result in injury, and/or illness and I hereby release the spa, therapist/esthetician, Aveda Corporation, and its parent company from any claims resulting from such. Any information provided to me by the therapist/esthetician is for general purposes only and is not intended for any medical purpose.

Client Signature _____ Date ___ / ___ / ____

Therapist Signature _____ Date ___ / ___ / ____