

Belle Ross Spa & Salon
Facial Confidential Consultation

(Please print) Name _____ Address _____
Phone _____ Cell Carrier for text _____ City _____ State _____ Zip _____
Birthday _____ Email _____

Your Health:

Within the last year, have you been under a dermatologist's or under physicians care? Yes or No
Within the last nine months, have you undergone any surgery? Yes or No If yes, please specify _____
Have you had any health problems in the past or present? Yes or No If yes, please specify _____
List any medications, supplements vitamins, diuretics, slimming tablets, etc that you take
regularly _____
Do you Smoke? Yes or No Do you exercise regularly? Yes or No
Do you have metal implants, a pacemaker? Yes or No Do you follow a restricted diet? Yes or No

Your Skin:

Skin type: please check
Normal _____ Dry _____ Sensitive _____
Combination _____ Oily _____ Breakouts _____
Very sensitive/rosacea _____ Acne _____ Mature _____
Eye Area: Please circle: Crows feet/wrinkles puffiness lack of elasticity dark shadows
How often do you receive facials: Please Circle: Regularly seldom never
Do you have special skin problems pertaining to your face? Yes or No – If yes specify _____
What skin care products are you currently using? Please circle below
Soap cleanser toner moisturizer exfoliator eye products

Exfoliation History:

Have you ever had a chemical peel, microdermabrasion or any resurfacing treatments? Yes or No In the last month?
Do you use accutane, retin-A, Renova, Adapalene or any other prescription skin products? Yes or No In the last 3 mths?
Are you currently using any products that contain the following? Glycolic acid Lactic acid exfoliating scrubs
Hydroxyl acid products vitamin A derivative (i.e. retinol)

Moisture Hydration:

How much plain water do you consume daily? _____glasses How many alcoholic beverage do you consume weekly?
What SPF sunscreen do you use on your face? _____ Do you sunbathe or use tanning beds? Yes or No
Do you ever experience these following conditions on your face? Flakiness tightness obvious dryness

Capillary Activity:

Do you burn easily in moderate sunlight? Yes or No Do you blush easily when nervous? Yes or No
Do you have a tendency to redness? Yes or No Do you suffer from sinus problems? Yes or No

Oil Secretion:

Do you ever experience oily shine during the day? Yes or No or Occasionally
Do you ever experience skin breakouts? Yes or No or Occasionally

Nerve Activity:

Do you drink more than 4 caffeinated beverages daily? (Coffee, tea, soft drinks) Yes or No
Do you ever experience a burning itching sensation on your skin? Yes or No
What is your pain threshold? Please circle - Low Medium High
Have you ever had a reaction to any of the following? Cosmetics medicines iodine pollen food hydroxyl acids
Animal's sunscreen other? _____

Female clients only: Are you taking oral contraception's? Yes or No Are you pregnant? Yes or No Are you lactating? Yes or No

Male clients only: What is your current shaving system? Electric or Blade Do you experience irritation from shaving? Yes or No
Do you experience ingrown hairs? Yes or No

Questions to discuss every visit:

Are you currently having or due for your menstrual period? Yes or No

Have you started any new medication since your last visit? Yes or No

Have you had any recent dental x-rays? Yes or No

What are your skin care goals? _____

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment

Client Signature _____ Date _____

Client Signature _____ Date _____

Client Signature _____ Date _____

Treatment Record – Therapist Only

Date	Treatments/Products used Notes	Samples given

