Executive Salon Suites ∫ 307 W. Main Street ∫ Suite, 200∫ Room 10 ∫ Frisco, Texas 75034

Date: _____

Name: _____

Date of Birth: _____ **Address**: _____

Home Phone: _____ **Business Phone**: _____

Cell Phone: _____ **E-mail address**: _____

Single: Yes ◯ No ◯ **Married**: Yes ◯ No ◯ **Married**: If yes, anniversary date: _____

Employer: _____

Occupation: _____ Does your job require that you work outdoors?
(***PLEASE CHECK ONE OF THE FOLLOWING ANSWERS***) YES ◯ NO ◯

Referred by:

_____

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

_____

_____

Your Skin Care History

(1) Have you ever had a facial treatment before? ◯ Yes ◯ No, when? _____

(2) Have you ever had a body spa treatment before? ◯ Yes ◯ No, when? _____

(3.) Have you ever had any of the following spa treatments: ◯ No ◯ Yes (**If yes)** when? _____

Massage: ◯ No ◯ Yes
Salt glow: ◯ No ◯ Yes
Seaweed wrap: ◯ No ◯ Yes
Mud Bath: ◯ No ◯ Yes
Body scrub: ◯ No ◯ Yes

Other_____

(4.) Which of the following best describes your skin type? (**Please circle one type number**):

(I.) **Creamy complexion**	**Always burns easily, never tans**
(II.) **Light Complexion**	**Always burns, tans slightly**
(III.) **Light/Matte Complexion**	**Burns moderately, tans gradually**
(IV.) **Matte Complexion Seldom**	**burns, always tans well**
(V.) **Brown Complexion**	**Rarely burns, deep tan**
(VI.) **Black Complexion**	**Never burns, deeply pigmented**

(5.) Do you have any special skin problems or concerns pertaining to your face or body? ◯ Yes ◯ No
Please specify: _____

(6.) Have you ever had the following treatments if so please check yes or no and date of last treatments?

Chemical peels	◯Yes ◯ No	When _____
Laser/Resurfacing	◯Yes ◯No	When_____
Microdermabrasion	◯Yes ◯No	When_____

(7.) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products?
◯ Yes ◯NO (If yes please indicate which product and how often it is used)
_____
_____

(8.) Have you used an acne medication? ◯ Yes ◯ No, when? _____ Which drug? _____

(9.) What skin care products are you currently using? (List brand name if known)_____

(10.) Have you recently used any self-tanning lotions, creams or treatments? ◯ Yes ◯No,
(Please specify):_____

(11.) Have you used any of the following hair removal methods in the past six weeks? ◯ Yes ◯ NO (Please circle all that apply).

Shaving Waxing Electrolysis Plucking/ Tweezing Threading Chemical Depilatories

(12.) What areas of concern do you have regarding your skin: (Please check any that apply and explain):

T-Zone ◯ dehydrated/dry ◯ oily ◯ breakout(s) ◯ wrinkles ◯ milia ◯ other: _____

Eyes: ◯ dehydrated/dry ◯ wrinkles ◯ puffiness ◯ dark circles ◯ milia ◯ other: _____

Lips: ◯ dehydrated/dry ◯ cracked/chapped lips ◯ other: _____

Chin: ◯ dehydrated/dry ◯ breakout ◯ oily ◯ inflammation ◯ other: _____

Ears: ◯ dehydrated/dry ◯ breakout(s) ◯ other: _____

(13.) Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain) (If yes, please give the name of the product that caused the reaction)

◯ Soap_____ ◯ Toner _____
◯ Mask _____ ◯ Eye Products_____
◯ Cleanser _____ ◯ Day Moisturizer _____
◯ Exfoliator _____ ◯ Scrubs _____
◯ Shower Gels _____ ◯ Body Lotions _____
◯ Sunscreen_____ ◯ SPF_____
◯ Night Moisturizer/Cream_____ ◯ Other_____
◯ Makeup Products _____

14) What SPF do you use on your face? _____ How often/when? _____

(15.) What SPF do you use on your body? _____ How often/when? _____

(16.) Have you had any recent tanning bed or sun exposure that changed the color of your skin? m No m Yes
specify:_____

(17.) Have you experienced Botox, Restylane or Collagen injections? m No m Yes
specify:_____

Female Clients Only:

(18.) Are you taking oral contraceptives? ◯ Yes ◯ No
specify:_____

(19.) Any recent changes to or from your contraceptive treatment? ◯ No ◯ Yes; If so, what and when:
_____

(20.) Are you pregnant or trying to become pregnant? m No m Yes

(21.) Are you lactating? ◯ Yes ◯ No

(22.) Any menopause problems? ◯ No ◯ Yes specify:_____

(23) Are you undergoing any hormone replacement therapy? ◯ Yes ◯ No Please specify
_____

Male Clients Only:

(24) What is your current shaving system? ◯ Wet shave or ◯ Electric (Please check one of the answers)

25) Do you experience irritation from shaving? ◯ Yes ◯ No ⌡Ingrown hairs? ◯ No ◯ Yes⌡ Please use the space below to complete answers where space was insufficient. (Please include the number of the question)

_____
_____

Future Appointments/Contact: May I call/text you utilizing the numbers that you have provide, work or cell phone number to confirm future appointments? ◯ Yes ◯ No May I contact you via mail/email about future promotions and news? ◯ Yes ◯ No I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

Client Name (printed) _____

Client Name (signature) _____ Date:_____

Guardian Name (printed) _____
(Applies if client is under the age of 18)

Guardian Name (signature) _____ Date: _____

Esthetician (signature) _____ Date: _____