shuswap SPA THERAPY

Name:

Confidential Facial Consultation Form

1. Within the last year, have you been under a dermatologist's or other physician's care? Yes ☐ No ☐

If yes, please specify_____

2. Within the last nine months, have you undergone any surgery? Yes ☐ No ☐

If yes, please specify_____

3. Have you had any health problems in the past or present? Yes ☐ No ☐

If yes, please specify_____

4. List any medications, supplements, vitamins, diuretics, slimming tablets, etc. that you take regularly:

_____

5. Do you exercise regularly? Yes ☐ No ☐

6. Do you follow a restricted diet? Yes ☐ No ☐

7. Do you have metal implants, a pacemaker or facial piercings? Yes ☐ No ☐

8. Rate your level of stress on a scale of 1 to 4 (1 = low stress, 4 = high stress) 1 ☐ 2 ☐ 3 ☐ 4 ☐

***9. Do you have any special skin problems pertaining to your face or body? Yes ☐ No ☐**

If yes, please specify_____

10. What skincare products are you currently using?

Face: Soap ☐ Cleanser ☐ Toner ☐ Moisturizer ☐ Masque ☐ Exfoliant ☐ Eye Products ☐

Body: Soap ☐ Shower Gel ☐ Scrubs ☐ Oil ☐ Body Moisturizer ☐ Depilatory Product ☐ Self Tanner ☐

What brands of skincare are you currently using?_____

11. Have you ever had a reaction to any of the following?

Cosmetics☐ Medicine☐ Iodine☐ Pollen☐ Food☐ Hydroxy Acids☐ Animals☐ Fragrance☐ Sunscreens☐

Other:_____

12. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? Yes ☐ No ☐

In the last month? Yes ☐ No ☐

13. Do you ever use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products? Yes ☐ No ☐

In the last three months? Yes ☐ No ☐

14. Are you currently using any products that contain the following ingredients?

Glycolic Acid ☐ Lactic Acid ☐ Exfoliating Scrubs ☐ Hydroxy Acid Products ☐ Vitamin A Derivatives ☐

shuswap SPA THERAPY

Name:

15. Do you experience any of these conditions on your skin? Flakiness ☐ Tightness ☐ Obvious Dryness ☐

16. What SPF sunscreen do you use on your face?_____ Body?_____

17. Do you sunbathe or use tanning beds? Yes ☐ No ☐

18. Do you burn easily in moderate sunlight? Yes ☐ No ☐

19. Do you blush easily when nervous? Yes ☐ No ☐

20. Do you have a tendency to redness? Yes ☐ No ☐

21. Do you suffer from sinus problems? Yes ☐ No ☐

22. Do you ever experience oily shine during the day? Yes ☐ No ☐ Occasionally ☐

23. Do you ever experience skin breakouts? Yes ☐ No ☐ Occasionally ☐

24. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks) Yes ☐ No ☐

25. Do you ever experience a burning, itching sensation on your skin? Yes ☐ No ☐

26. Have you experienced claustrophobia? Yes ☐ No ☐

Female Clients Only

27. Are you taking oral contraception? Yes ☐ No ☐

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

29. Are you pregnant or trying to become pregnant? Yes ☐ No ☐

30. Are you lactating? Yes ☐ No ☐

Questions to Discuss Every Visit

31. Have you started any new medication since your last visit? Yes ☐ No ☐

32. Have you had any recent dental x-rays within the last six weeks? Yes ☐ No ☐

33. Have you been under general anesthesia within the last six weeks? Yes ☐ No ☐

34. Have you had any fillers or injectables within the last six weeks? Yes ☐ No ☐

***35.** **What are you skincare goals during today's appointment?**_____

***36.** **What are your long term skincare goals?**_____

Signature _____ **Date:** _____