Facial Release Form

Client Name _____ Date:_____

Address_____

City_____ State_____ Zip Code_____

Email _____

Cell#_____ Wk#_____ Home# _____

Birthday _____ /_____/_____ Who referred you to us?_____

How did you hear about Serendipity Massage and Spa? _____

What is your main reason for visiting the spa today? _____

Are you interested in ___Skin Care ___Massage ___ Body Treatments

Are you interested in a treatment program? ___ Yes ___No ___Don't Know

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The following information helps us understand our personal skin care needs.
All information is completely confidential and will only be used for this consultation.

LIFESTYLE FACTORS

Are you currently or within the past year under a physicians care? ___Yes ___No

Have you undergone surgery in the last year? ___Yes ___No

if yes, please explain _____

Are you under the care of a dermatologist? ___Yes ___No for what?_____

Do you smoke? ___Yes ___No On average, do you work more than 9 hours per day? ___Yes ___No

Have you had any of the following? ___Cancer ___Epilepsy ___Hormone Imbalance ___Thyroid condition

___Diabetes ___Heart Problems ___Hysterectomy ___Varicose veins

List any medications, vitamins and topical prescription creams used regularly:

Medications:_____

Vitamins: _____

Prescription Creams: _____

Are you allergic to aspirin? ___Yes ___No Are you allergic to Aloe Vera? ___Yes ___No

Do you use Retin-A? ___Yes ___No Have you ever used Accutane? ___Yes ___No

Do you exercise regularly ___Yes ___No What temperature is your cleansing water?___Cool__Warm___Hot

Do you have any implanted metal devices? ___Yes___No if yes, please explain _____

Do you have any allergies? ___Yes ___No please list _____

What types of skin care are you currently using? ___Soap ___Cleanser ___Toner ___Scrub/Peel/Exfoliant

___Masque ___Eye gel/cream ___Neck cream ___Glycolic/AHA ___Sun Block

What are your skin care concerns? _____

Are you achieving the desired results with your current beauty regimen? ___Yes ___No

When was the last time you had a facial? _____

OIL SECRETION

Do you experience oily shine during the day? ___Yes ___No

Do you experience skin breakouts? ___Yes ___No if yes, please explain_____

MOISTURE/HYDRATION

How much plain water do you consume daily? _____

Do you take laxatives or diuretics? ___Yes ___No ___Occasionally

Which of the following skin conditions do you experience: ___Flakiness ___Tightness ___Obvious dryness

Do you use sunscreen on your skin? ___Yes , SPF_____ how often?_____ ___No

CAPILLARY ACTIVITY

Do you burn easily in moderate sunlight? ___Yes ___No Have you ever suffered sinus problems? ___Yes ___No

NERVE ACTIVITY

How many cups of caffeinated beverages do you drink daily? ___None ___1-3 cups ___4 or more

Do you take any diet pills or other stimulants? ___Yes ___No ___occasionally

Have you ever experienced claustrophobia? ___Yes ___No

Have you ever had a reaction to any of the following:

___Cosmetics ___Fragrance ___Animals ___Pollen/Molds ___Food ___Metals

Female Clients Only

Are you taking oral contraception? ___Yes ___No Are you pregnant or attempting? ___Yes ___No

Are you currently having or are due for your menstrual period? ___Yes ___No

Are you currently taking Hormone Replacement Therapy? ___Yes ___No

If you are currently in menopause, when was your last period? _____

Do you experience any menopausal symptoms? ___Yes ___No Please explain _____

Male Clients Only

What is your current shaving system? ___Wet ___Electric

Do you experience irritation from shaving? ___Yes ___No

Do you experience ingrown hairs? ___Yes ___No

_____ _____

signature date