Beauty Beyond Make-Up

# Client Consultation Form

Client Information and Consent

Name

DATE

Occupation

Address

City

Zip

Phone

Email

## SKINCARE HISTORY

| | | Yes | No |
|---|---|---|---|
| 1. | Do you have any experience with facial treatments or chemical peels? | ☐ | ☐ |
| 2. | Do you use skincare products for acne and anti-aging? | ☐ | ☐ |
| 3. | During the past 48 hours, have you used skincare products for treating surface wrinkles, improving skin texture and tone, unblocking and cleansing pores? | ☐ | ☐ |
| 4. | Do you take medicine to reduce the amount of oil released by oil glands in your skin or have you taken it in the past? | ☐ | ☐ |
| 5. | Do you use a tanning bed or are you exposed to the sun daily? | ☐ | ☐ |

**What skincare products are you currently using?**

1.

2.

3.

4.

5.

6.

## HEALTH HISTORY

| | | Yes | No |
|---|---|---|---|
| 1. | Are you pregnant or breastfeeding? | ☐ | ☐ |
| 2. | Do you have any neck or shoulder injuries? | ☐ | ☐ |
| 3. | Are you allergic to any foods or medication? | ☐ | ☐ |

**- Back side -**

| | Yes | No |
|---|---|---|
| **4.** Have you had Botox or similar within the last 7 days? | ☐ | ☐ |
| **5.** Are you prone to epilepsy, light sensitive or seizures? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| **I am aware that it is my duty to submit truthful information.** | ☐ | ☐ |

Signature