EFFLEURAGE STUDIO

Facial | Wax | Lash

CONSULTATION CHART

Name _____

Address _____ City _____ State _____ Zip Code _____

Telephone _____ Email _____ Birthdate _____

Date of Consultation _____ How did you hear of us? _____

Occupation _____ M ☐ F ☐

CLIENT HISTORY - *WE CAN ACHIEVE YOUR GOALS ONLY IF YOU ARE HONEST WITH YOUR ANSWERS*

1. Are you now or within the last year under a physician's care? Dermatologist? Plastic Surgeon?
☐ Yes ☐ No
If yes, specify _____

2. Have you undergone any surgery in the last nine months?
☐ Yes ☐ No
If yes, specify _____

3. Have you had any of these health problems past or present?

☐ Cancer	☐ Hormone Imbalance
☐ Diabetes	☐ Hysterectomy
☐ Epilepsy	☐ Thyroid
☐ Heart Problem	☐ Varicose Veins
☐ HIV or AIDS	☐ Facial Warts
☐ STDs	☐ Drug Addiction
☐ Hepatitis	☐ Cold Sores

4. List any medications and vitamins that you take regularly:
_____
_____
condition(s): _____

5. Do you have permanent make-up?
☐ Yes ☐ No
If yes, where _____

6. Do you have any special skin problems or concerns pertaining to your face?
☐ Yes ☐ No
If yes, specify _____

7. Do you have any special concerns pertaining to your body?
☐ Yes ☐ No
If yes, specify _____

8. Do you:

smoke	☐ Yes	☐ No
use Retin-A	☐ Yes	☐ No
ever use Accutane	☐ Yes	☐ No
follow a restricted diet	☐ Yes	☐ No
exercise regularly	☐ Yes	☐ No
have regular sleep patterns	☐ Yes	☐ No
have chemically lightened hair	☐ Yes	☐ No
wear contact lenses	☐ Yes	☐ No

9. What types of skin care products are you currently using daily?
☐ soap/cleanser ☐ toner ☐ serums
☐ scrub ☐ moisturizer ☐ sunblock
☐ acne spot treatment ☐ skin bleacher
Indicate WEEKLY use of:
☐ scrub/peel/microdermabrasion cream
☐ masque: _____
☐ other _____

10. Have you ever had a facial treatment before?
☐ Yes ☐ No
If yes, specify _____

11. Have you ever had plastic surgery?
☐ Yes ☐ No
If yes, specify _____

12. Have you ever had
☐ Chemical Peel ☐ Microdermabrasion
☐ Botox ☐ IPL (Photo Facial)
☐ Laser Hair Removal ☐ Laser Resurfacing
☐ Facial Filler (e.g. Restaylane/Collagen)

FEMALE CLIENTS ONLY

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

2. Are you or now trying to become pregnant?
☐ Yes ☐ No ☐ Breast feeding?

MALE CLIENTS ONLY

1. What is your current shaving system?
☐ Wet ☐ Electric

2. Do you ever experience irritation from shaving?
☐ Yes ☐ No

3. Do you experience ingrown hairs?
☐ Yes ☐ No

4. Do you wish you could get a closer shave?
☐ Yes ☐ No

OIL SECRETION

1. Do you experience breakthrough oily shine during the day?
☐ Yes ☐ No

2. Do you experience skin break-outs?
☐ Yes ☐ No ☐ Occasionally

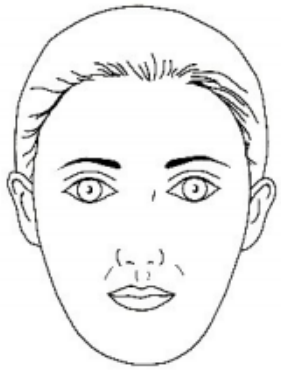
MOISTURE HYDRATION

1. How many glasses of plain water do you consume daily?
☐ None ☐ 1-3 ☐ 4-7 ☐ 8 or more

2. How many alcoholic beverages do you consume weekly?
☐ None ☐ 1-3 ☐ 4 or more

3. Do you ever experience any of the following conditions on your skin?
☐ Flakiness ☐ Tightness ☐ Obvious dryness

4. Do you use a sunscreen/sunblock?
☐ Always ☐ Sometimes ☐ Never
☐ Only when I go outside
What SPF do you use? _____



ESTHETICIAN COMMENTS

CAPILLARY ACTIVITY

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

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

3. When/if drinking alcohol, do your cheeks turn red?
☐ Yes ☐ No
Spicy food?
☐ Yes ☐ No

4. When/if eating salt, do you experience puffy skin (possibly around the eye area)?
☐ Yes ☐ No

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

6. Have you ever suffered any sinus problems?
☐ Yes ☐ No

NERVE ACTIVITY

1. How many cups of caffeine-type beverages (coffee, tea, soft drinks) do you drink daily?
☐ None ☐ 1-3 ☐ 4 or more

2. What level do you consider your pain threshold to be?
☐ Low ☐ Medium ☐ High

3. Have you ever experienced any claustrophobia?
☐ Yes ☐ No

4. Have you ever experienced a reaction to any of the following?

☐ Cosmetics	☐ Pollen	☐ Aspirin
☐ Medicine	☐ Food	☐ Glycolic Acid
☐ Iodine	☐ Shellfish	☐ Hydroquinone
☐ Fragrance	☐ Milk	☐ Sunscreens
☐ Sulfa	☐ AHAs	☐ Animals
☐ Sulfur		

☐ Other: _____

QUESTIONS TO UPDATE EACH VISIT

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

2. Have you started any new medications?
☐ Yes ☐ No
If yes, specify _____

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: _____

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EFFLEURAGE STUDIO

Facial | Wax | Lash

(OFFICE USE ONLY)

RECOMMENDED REGIMEN			
AM	PM	Weekly	VMD

OTHER RECOMMENDED TREATMENTS

TODAY'S DATE