Name: ____ **Date:** ____________

By completing this client profile, you will assist us in evaluating your specific condition. The information you provide will be used to determine what factors may be affecting you so that we may recommend the proper care.

Address: ________________________________

________________________________ Phone #: ________________________

________________________________ Email: __________________________

Whom may we thank for your referral? ________________________________ Birth Date: _______________________

Would you like to be added to our email list for discounts & specials? ☐ yes ☐ no Age: ____________________________

Emergency Contact:

Option 1: ________________________________ Phone #: ________________________

Health/Medical *(Please answer to the best of your knowledge)*

Please list all medications that you take regularly. Include hormones, vitamins, etc.:

____

Please circle any health conditions which **you have had** or are **now experiencing**

Cancer	Body Piercings	Epilepsy	Seizures	Lupus
Thrombosis	Phlebitis	Hemophilia	HIV	Hepatitis
Recent Illness	Light Sensitivity	Heart Problems	Pacemaker	Alcoholism
Multiple Sclerosis	Metal Implants/Screws	Hormonal Disorders	Claustrophobia	Smoking
Hypoglycemia	Asthma	Thyroid Disorders	Muscular Conditions	High/Low Blood Pressure
Diabetes	Lack of Normal Skin Sensation	Recent Surgery	Whiplash	

Do you have circulation or respiratory problems? ___________

Do you have a clotting disorder? ____________

List any allergies that cause hives or anaphylactic shock: ____

List anything that may cause reactions to your skin? ____

Have you ever undergone treatment from a dermatologist? ☐ yes ☐ no

If yes, when? _______________________________________ Any negative side effects? ____

Have you ever undergone treatment from an aesthetician? ☐ yes ☐ no

If yes, when? ____ What type of condition? ____

Any negative side effects? ____

Within the last month, have you taken or used any of the following?

Retin-A ☐ Antibiotics ☐ Diuretics ☐

Accutane ☐ Oral Contraceptives ☐ Laxatives ☐

Have you ever undergone plastic surgery? ☐ yes ☐ no

If yes, when? ____

Where on your body? _____________________________________

What information can you provide about the procedure?

____

Female Clients Only

Are you taking oral contraception? ☐ yes ☐ no

Are you pregnant or trying to become pregnant? ☐ yes ☐ no

Are you lactating? ☐ yes ☐ no

Are you currently having or due for your menstrual period**?** ☐yes ☐ no

Male clients Only

Do you have any shaving challenges**?** ☐ yes ☐ no

If yes, please specify ____

Questions to discuss every visit

Have you started any new medication since your last visit?

Nutrition/Diet

Check any of the following foods that you consume and indicate the amount per day:

Sugar ☐ __________ Spicy Foods ☐ __________ Dairy Products ☐ __________

Salty Foods ☐ __________ Snack Foods ☐ __________ Meat Products ☐ __________

Check the types of fluids that you consume daily and indicate the amount per day:

Water ☐ __________ Juices ☐ __________ Tea ☐ __________

Coffee ☐ __________ Alcohol ☐ __________ Sodas ☐ __________

Home Skin Care Regimen

Describe (using product brand names) how you are presently caring for your skin:

	AM	PM		AM	PM
Cleanser:	______________	________________	Exfoliant:	______________	________________
Toner:	______________	________________	Serum:	______________	________________
Moisturizer:	_____________	________________	SPF Sunscreen:	______________	______________
Make-Up:	______________	________________	Other:	______________	________________

How many hours do you sleep per night? ____________________

How often do you exercise? ______________________________

On a scale from 1 (low) to 10 (high), how would you rate your stress level? _______________________

How much sun exposure have you had? ____

What are your goals and expectations? ____

What specific concerns would you like to address today? _____________________________________

How long have you noticed your condition(s)? ____

Is this an ongoing or temporary condition? ____

What specific improvements do you wish to see? ____

In what time frame do you expect to reach your goals? _____________________________________

Have you ever received a spa treatment, if so, what type? ___________________________________

What were the results? ____

What is the primary reason for receiving your service today? __________________________________

How often do you receive the service you are here for? ☐ regularly ☐ seldom ☐ never

<u>Oil Secretion</u>

Do you experience oil shine during the day? ☐ yes ☐ no

Do you experience breakouts? ☐ yes ☐ no

<u>Moisture/Hydration</u>

Do you ever experience these conditions on your skin? ☐ flakiness ☐ tightness ☐ obvious dryness

<u>Skin Sensitivity</u>

Please answer these questions rating your sensitivity. 1 (moderate) 5 (extreme)

How sensitive is your skin? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How much of a tendency to redness does your skin have? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What level do you consider your pain tolerance to be? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Previous esthetic treatments, check all that apply:

Dermal Fillers: Restylane/Juvaderm/Sculptra: Date:	Botox: Date:	Facials: Date:	Laser Treatments: Date:
IPL/Photorejuvenation: Date:	Chemical Peels: Date:	Microdermabrasion: Date:	Microcurrent: Date:
LED Light Therapy: Date:	Oxygen Infusion Treatment: Date:	Facial Waxing: Date:	Other: Date:

<u>This information is completely confidential and is used only for treatment analysis.</u>

<u>Our policy: We requite 24-hour notice for cancellations or change of appointments. In the event of a cancellation, your card will be charged 50% of the service fee. No shows will be charged 100% of the service fee. We thank you for your understanding of our time.</u>

I certify that the above statements are true and correct, and that I, ____, having been advised and fully informed by ________________________________ of Fabu Face Spa concerning the nature of the process proposed, to be performed by them, and hereby authorize and direct them to perform such process and perform such services as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1) I have read, understand, and fully agree to the foregoing (2) Understand the caution and contraindications for each process and service proposed (3) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire (4) I hereby give my consent and authorization voluntarily and release Fabu Face Spa and its agents of any claims that I have or may have in the future in connection with the described application or service.

____ client signature