BELLE ROSS
SPA & SALON

Belle Ross Spa & Salon Facial Confidential Consultation

(Please print) Name ______________________________ Address_______________________________________
Phone _________________ Cell Carrier for text________ City _____________State____________Zip__________
Birthday __________ Email ____

Your Health:

Within the last year, have you been under a dermatologist's or under physicians care? Yes or No
Within the last nine months, have you undergone any surgery? Yes or No If yes, please specify ___________________
Have you had any health problems in the past or present? Yes or No If yes, please specify _____________________
List any medications, supplements vitamins, diuretics, slimming tablets, etc that you take regularly____
Do you Smoke? Yes or No Do you exercise regularly? Yes or No
Do you have metal implants, a pacemaker? Yes or No Do you follow a restricted diet? Yes or No

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Your Skin:

Skin type: please check

Normal___ Dry___ Sensitive___
Combination___ Oily___ Breakouts___
Very sensitive/rosacea___ Acne___ Mature___

Eye Area: Please circle: Crows feet/wrinkles puffiness lack of elasticity dark shadows
How often do you receive facials: Please Circle: Regularly seldom never
Do you have special skin problems pertaining to your face? Yes or No – If yes specify__________________________
What skin care products are you currently using? Please circle below
Soap cleanser toner moisturizer exfoliator eye products

Exfoliation History:

Have you ever had a chemical peel, microdermabrasion or any resurfacing treatments? Yes or No In the last month?
Do you use accutane, retin-A, Renova, Adapalene or any other prescription skin products? Yes or No In the last 3 mths?
Are you currently using any products that contain the following? Glycolic acid Lactic acid exfoliating scrubs Hydroxyl acid products vitamin A derivative (i.e. retinol)

Moisture Hydration:

How much plain water do you consume daily? _______glasses How many alcoholic beverage do you consume weekly?
What SPF sunscreen do you use on your face? ________ Do you sunbathe or use tanning beds? Yes or No
Do you ever experience these following conditions on your face? Flakiness tightness obvious dryness

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Capillary Activity:

Do you burn easily in moderate sunlight? Yes or No Do you blush easily when nervous? Yes or No
Do you have a tendency to redness? Yes or No Do you suffer from sinus problems? Yes or No

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Oil Secretion:

Do you ever experience oily shine during the day? Yes or No or Occasionally
Do you ever experience skin breakouts? Yes or No or Occasionally

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Nerve Activity:

Do you drink more than 4 caffeinated beverages daily? (Coffee, tea, soft drinks) Yes or No
Do you ever experience a burning itching sensation on your skin? Yes or No
What is your pain threshold? Please circle - Low Medium High
Have you ever had a reaction to any of the following? Cosmetics medicines iodine pollen food hydroxyl acids Animal's sunscreen other? ________________________

Female clients only: Are you taking oral contraception's? Yes or No Are you pregnant? Yes or No Are you lactating? Yes or No

Male clients only: What is your current shaving system? Electric or Blade Do you experience irritation from shaving? Yes or No
Do you experience ingrown hairs? Yes or No

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Questions to discuss every visit:

Are you currently having or due for your menstrual period? Yes or No
Have you started any new medication since your last visit? Yes or No
Have you had any recent dental x-rays? Yes or No
What are your skin care goals? ____

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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 ______________________________________Date______________________
Client Signature ______________________________________Date ______________________
Client Signature ______________________________________Date ______________________

Treatment Record – Therapist Only

Date	Treatments/Products used Notes	Samples given