DIANA O'DONNELL
SKIN CARE

Client Consultation Form

First Name: _____ Last Name:_____

Address: _____ City: _____ State: ___ Zip:_____

Cell Phone: (____) ____-_____ Home Phone: (____) ____-_____ Email: _____

Date of Birth: _____ Occupation: _____ ☐ Female ☐ Male

Emergency Contact:_____ Relationship:_____ Phone: (___) ___-_____

Referred by: _____ Have you had a facial treatment before? Yes ❑ No ❑

If yes, what type of treatment(s)? _____

What are your goals for your treatment today?_____

1. What type of facial cleanser(s) do you use? (please check all that apply)

❑ Facial Wash/Gel ❑ Cleansing Milk ❑ Cleansing Oil ❑ Creamy Cleanser ❑ Bar Soap ❑ None

What brand is it? _____

2. Do you use a moisturizer? Yes ❑ No ❑

3. Do you use a glycolic acid product on a regular basis? Yes ❑ No ❑

4. Are you using Retin-A, Differin or any other Retinol products? Yes ❑ No ❑

If yes, please specify: _____

5. Are you / have you taken Accutane or any other acne medication? Yes ❑ No ❑

If yes, please specify: _____

6. Are you allergic to anything? Yes ❑ No ❑

If yes, please specify: _____

7. Are you presently taking any medication? Yes ❑ No ❑

If yes, please specify: _____

8. Do you experience redness or irritation often? Yes ❑ No ❑

9. Do you have a cold sore, or do you get cold sores? Yes ❑ No ❑

10. Are you a diabetic? Yes ❑ No ❑

11. Have you ever been diagnosed with Rosacea by a doctor? Yes ❑ No ❑

12. Are you claustrophobic? Yes ❑ No ❑

13. Do you have asthma? Yes ❑ No ❑

14. Have you had Botox, dermal fillers, facial surgery or laser in the last 2 weeks? Yes ❑ No ❑

15. Do you have heart trouble? Yes ❑ No ❑

16. Do you have a pacemaker? Yes ❑ No ❑

17. Do you have any metal plates or pins implanted in your body? Yes ❑ No ❑

18. Do you smoke? Yes ❑ No ❑

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19. On average, how many hours a week do you spend in the sun? _____ hours

20. Are you pregnant? Yes ❑ No ❑

If yes, number of weeks? _____

21. Do you consider your skin sensitive? Yes ❑ No ❑

22. Which of the following best describes your skin type?

❑ **Type I**: Fair skin tones; always burns, never tans ❑ **Type II**: Light skin tones; burns easily, tans slightly
❑ **Type III**: Fair-olive skin tones; burns/tans moderately ❑ **Type IV**: Light brown skin; burns lightly, tans easily
❑ **Type V**: Rarely burns, tans easily ❑ **Type VI**: Dark brown-black skin tones; never burns, tans easily

23. How would you describe your skin? ❑ Very Dry ❑ Dry ❑ Normal ❑ Combination ❑ Oily ❑ Very Oily

24. Is your skin tan right now as a result of sun exposure or a tanning bed? Yes ❑ No ❑

25. Have you recently used any self-tanning lotions, creams, sprays or treatments? Yes ❑ No ❑

26. What areas of concern do you have for your skin? *Please check all that apply:*

❑ Breakouts / acne	❑ Uneven skin tone	❑ Redness	❑ Blackheads/Whiteheads
❑ Sun damage	❑ Excessive oil or shine	❑ Dull complexion	❑ Wrinkles / Fine lines
❑ Flaky skin	❑ Dry skin	❑ Broken capillaries	❑ Sun / liver / brown spots
Eyes: ❑ Dehydrated	❑ Wrinkles/Fine Lines	❑ Puffiness	❑ Dark circles
Lips: ❑ Dehydrated	❑ Cracked/chapped lips		

27. Have you used any hair removal methods on your face in the last two weeks? Yes ❑ No ❑

If yes, please check all that apply: ❑Shaving ❑Waxing ❑Tweezing ❑Electrolysis ❑Threading ❑Depilatory

Please list any medications you take: _____

Which of the following are part of your daily/nightly skin care routine?

❑Cleanser ❑Toner ❑Serum ❑Exfoliant ❑Moisturizer ❑Eye Cream ❑Mask ❑Neck/Chest Cream ❑SPF

Please list the skin care brands that you currently use, or prefer: _____

_____

CONSENT TO TREATMENT

I understand if I experience any pain or discomfort during my treatment, I will immediately inform the Esthetician so the treatment can be adjusted to my level of comfort. I further understand that skin care treatments should not be construed as a substitute for medical examination, diagnosis or treatment and I should see a physician for any mental or physical ailment I am aware of or concerned about. I understand and 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. I agree to keep Diana O'Donnell Skin Care updated as to any changes in my medical profile and understand that there shall be no liability on Diana O'Donnell Skin Care's or Diana O'Donnell's part should I forget to do so. I will also contact Diana O'Donnell Skin Care / Diana O'Donnell should I have a reaction to either the treatment performed or recommended products.

Client Signature: _____ Date: ____/____/_____

If client is under 16:

Parent or Guardian Signature: _____ Date: ____/____/_____