



## Esthetician Client Consultation and Policy Agreements

Date: \_\_\_\_\_ Esthetician Name: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Referred by: \_\_\_\_\_

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### History

1. Is this your first facial treatment?  yes  no
  2. What special area of concern do you have?  
\_\_\_\_\_
  3. Are you currently under physician care?  yes  no  
If yes, what for? \_\_\_\_\_
  4. Are you pregnant?  yes  no
  5. Are you taking birth control pills?  yes  no
  6. Are you taking Hormone Replacement?  yes  no
  7. Do you wear contact lenses?  yes  no
  8. Do you smoke?  yes  no
  9. Do you often experience stress?  yes  no
  10. Are you using or have you used any of the following?  
 Retin-A  Renova  AHA/BHA  Glycolics
  11. Are you using or have you used Accutane?  
 yes  no If yes, when? \_\_\_\_\_
  12. Have you had peels, laser, or microderm?  yes  no
  13. Have you had electrolysis or used depilatories in the  
past six weeks?  yes  no
  14. Do you experience frequent blemishes?  yes  no
  15. Are you sensitive to any fragrances?  yes  no
  16. Are you taking any medications?  yes  no
  17. Any recent surgery, including plastic?  yes  no
- Waxing History:**
18. Do you have tendencies for:  
 Ingrown hairs  Scarring  Bumps  Bruising  
 Hyperpigmentation
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### Health

Have you had any of these health conditions in the past or present? (Please check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cancer (any type)          | <input type="checkbox"/> Hormone imbalance               | <input type="checkbox"/> Systemic disease        |
| <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Spinal injury                   | <input type="checkbox"/> Thyroid condition       |
| <input type="checkbox"/> Allergies (any type) _____ | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Heart problem           |
| <input type="checkbox"/> Pacemaker                  | <input type="checkbox"/> Varicose veins                  | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Eczema                          | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Fever blisters                  | <input type="checkbox"/> Headaches (chronic)     |
| <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Herpes Simplex                  | <input type="checkbox"/> Frequent cold sores     |
| <input type="checkbox"/> Immune disorders           | <input type="checkbox"/> HIV/AIDS                        | <input type="checkbox"/> Lupus                   |
| <input type="checkbox"/> Metal bone pins/plates     | <input type="checkbox"/> Blood clots or poor circulation | <input type="checkbox"/> Psychological treatment |
| <input type="checkbox"/> Skin diseases/lesions      | <input type="checkbox"/> Keloid scarring                 | <input type="checkbox"/> Any active infection    |
| <input type="checkbox"/> Sinus problems             | <input type="checkbox"/> Skin reaction to any products   | <input type="checkbox"/> Other _____             |

## Skin Care

What skin care products are you currently using? (List brand where known)

Soap \_\_\_\_\_

Shower Gel \_\_\_\_\_

Toner \_\_\_\_\_

Body Lotion \_\_\_\_\_

Mask \_\_\_\_\_

Sunscreen \_\_\_\_\_

Eye Product \_\_\_\_\_

SPF \_\_\_\_\_

Cleanser \_\_\_\_\_

Night Moisturizer \_\_\_\_\_

Day Moisturizer \_\_\_\_\_

Other \_\_\_\_\_

Exfoliator \_\_\_\_\_

Makeup Products \_\_\_\_\_

Scrub \_\_\_\_\_

\_\_\_\_\_

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## Policies and Agreements

Please read the following Policies and Agreements carefully. The following information will be important, as it pertains to your session for today and all subsequent appointments. Feel free to ask any questions for clarity. Once you understand this document completely, please sign and date it at the bottom where indicated.

1. I understand, have read, and completed the questionnaire truthfully.
2. I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures.
3. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received.
4. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history.
5. I understand that the purpose of my visits with my esthetician is strictly for facials treatments and/or waxing services. This is not a substitute for medical diagnosis, examinations, treatments, or prescriptions regarding illness, ailment, or disease.
6. I understand that facial treatments often result in a breakout within a few days after treatment and that this is normal.
7. Waxing may cause bruises, scabs, scarring, redness, hyperpigmentation or pimples. Waxing of soft tissue may cause the skin to tear resulting in the need for stitches (most common occurrence is in Brazilian waxing.)
8. I understand that I am always in **complete control of my body** during each session and will freely comment regarding my comfort and/or discomfort at any time.
9. I agree to pay by cash, check or credit card at the time services are rendered. If my check bounces, I agree to pay a service fee of \$25. If any additional fines are incurred, with proof, I will cover those fees as well.
10. I understand that there is a **24-hour Notice of Cancellation** policy strictly enforced. Failure to do so will result in a fee 50% of the rate of the session scheduled. Any "no-show" of a given session will result in a fee of 100% of the total session scheduled.
11. If I am going to be late for an appointment, I understand that my session may end at the originally scheduled time and I will make full payment for the session as scheduled.
12. I agree to have **good personal hygiene** for each and every session.
13. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

### Other important items noted:

- For my own safety, I will not arrive under the influence of drugs or alcohol.
- For a more relaxing experience, my pager and cell phone will be turned off.
- The client is responsible for all personal belongings.
- Any and all information provided to esthetician will remain confidential... ***Your Privacy Is My Policy!***
- Finally, this form will be included with your master file. If you would like a copy, just ask. ***Thank you!***

**I accept all of the above policies and agreements.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Esthetician Signature

\_\_\_\_\_  
Date