Total U Skincare

Client Profile & Consent Form

Information captured within this document is kept strictly confidential.

Welcome and Thank You for choosing Total U Skincare. Please complete the following:

Date:_____/_____/ 20_____

Client Information

Name:_____ **Age:**_____ **DOB:**_____/_____/_____ **Sex:** M F

Address:_____ **City, State, Zip:**_____

Home / Work Phone:_____ **Cell:**_____

Email:_____ **Occupation:**_____

How did you hear about us? ☐ Website ☐ Social Media_____ ☐ Google ☐ Advertising_____
☐ Family / Friend_____ ☐ Other_____

Health & Medical Information

Physician Name:_____ **Office Number:**_____

Do you smoke? ☐ Yes ☐ No **How often?**_____ **Are you living with a smoker?** ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No Consumption? ☐ Daily ☐ Occasionally

Are you pregnant or lactating? ☐ Yes ☐ No ☐ N/A Expected date of delivery?_____/_____/_____
**Please consult with your physician and obtain clearance to receive any skincare treatments.*

List all medications you are currently taking **(Include over-the-counter, prescribed, topical, Birth Control, Vitamin Supplements, etc. – NOTE: antibiotics may increase skin sensitivity to a treatment)***:**

_____

Do you wear contact lenses? ☐ Yes ☐ No **Do you have permanent makeup?** ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No **If yes, how often?** ____ per ____ **Daily water intake:**_____oz / day

Daily caffeine intake:_____oz / day Please check all that apply: ☐ Coffee ☐ Tea ☐ Soda ☐ Other

Do you currently use / receive depilatories or waxing? ☐ Yes ☐ No **Last service:**_____

Do you currently have a sunburn / windburn / red face? ☐ Yes ☐ No **Explain:**_____

Are you prone to cold sores / fever blisters? ☐ Yes ☐ No **Last breakout:**_____

Do you use tanning beds? ☐ Yes ☐ No **How often?** ____ per ____ **Last session:**_____

Do you have or are you prone to *(Check all that apply)***:** ☐ Ingrown Hairs ☐ Scaring / Keloid ☐ Bumps
☐ Hyperpigmentation ☐ Bruising ☐ Diabetes ☐ Allergies ☐ Other_____

List all known allergies / skin sensitivities:

Please include milk, apples, citrus, grapes, aloe vera, aspirin, perfumes, latex, hydroquinone, mushrooms, and any other applicable allergy / skin sensitivity.

Are you sensitive to alcohol-based products? □ Yes □ No List any bad product reactions you have had:

_____

Have you been treated for *(Check all that apply)***:** □ Acne □ Depression □ Skin Disease □ High Blood Pressure □ Coldsores / Fever Blisters □ Diabetes □ Cancer □ Other_____

Have you used any of the following within the last 24 – 72hrs or 14 days? □ Accutane □ Retin-A □ Alphahydroxy Acid □ Glycolic Acid □ Resorcinol □ Body Scrub □ Chemical Skin Peel □ Microdermabrassion □ Other medical device / skin thinning medication_____

Have you recently had facial surgery / laser resurfacing? □ Yes □ No **When?**_____/_____/_____

Do you have regular collagen, Botox, or other dermal filler injections? □ Yes □ No If yes, last injection date _____/_____/_____

Overall, what is your skincare goal?_____

Have you ever been under the treatment plan of a(n) *(Check all that apply)***:**
□ Esthetician □ Dermatologist □ Plastic Surgeon - Would you be interested in Cosmetic Surgery? □ Yes □ No For what procedure:_____

On a scale of 1 (low) **– 10** (high)**, what is your current stress level?_____ normal stress level?_____**

Do you consider your skin to be: □ Sensitive □ Resilient □ Unsure

When you go out into the sun, do you *(select only one)***:** □ Always Burn (I) □ Usually Burn (II) □ Sometimes Burn (III) □ Rarely Burn (IV) □ Very Rarely Burn (V) □ Never Burn (VI)

Are you using a daily environmental protection product (sunblock)? □ Yes □ No If not, please explain why:_____

Please describe your skin *(Check all that apply)***:** □ Normal □ Dry □ Oily □ T-Zone / Combination □ Acne □ Milia □ Blackheads / Comodones □ Cysts □ Breakouts □ Acne Scared □ Large Pores □ Small Pores □ Thick □ Thin □ Saggy □ Firm □ Florid □ Rosacea □ Eczema □ Freckled □ Sun-damaged □ Melasma □ Hyperpigmentation □ Perfume-stained □ Hypopigmentation □ Uneven / Blotchy □ Mature □ Wrinkled □ Patchy Dryness □ Sallow □ Psoriasis □ Dehydrated / Lacking Moisture □ Asphyxiated □ Telangiectasia / Broken Surface Capillaries

On a scale of 1 (bad) **– 10** (fantastic)**, how do you feel about the overall quality of your skin?_____**

What skincare line are you currently using?_____

What is your current skincare routine AM and PM?_____

Is this your first skincare treatment experience? □ Yes □ No

In order of importance, please rank 1 (most important) to 5 (least important) improvement within the next 30 days: ____Reduction of Fine Lines _____Acne Scars Diminished ____Reduction of Brown Spots / Sun Damage ____Reduction of Redness ____Reduction of Oil / Acne

Please list any questions / concerns you may have about your skin that you would like to discuss with the Esthetician:_____

_____

Client Consent

I have read the above information and if I had any concerns, I have addressed them with my skincare specialist. I give permission to my skincare specialist to perform the skincare treatment(s) we have discussed and will hold him/her harmless from any liability that may result from this treatment.

_____
Client Initials

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy, recent facial treatments / surgery, allergies, tendency to cold sores / fever blisters, or use of topical and/or oral prescription medications.

_____
Client Initials

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc.

_____
Client Initials

I understand this is a cosmetic treatment and that no medical claims are expressed or implied. I understand that to achieve maximum results, I may need several treatments.

_____
Client Initials

I have received, read, and understand that I should follow my skincare specialist's recommendations for post-treatment care to minimize side effects and maximize results. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment, I will consult my skincare specialist immediately.

_____
Client Initials

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written statements. I certify that I have read and fully understand the above paragraphs and that I had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the skincare specialist performing my service responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

_____
Client Initials

_____ _____
Client Signature **Date**

_____
Print Client Name

_____ _____
*Parent/ Guardian Signature **Date**

**Required for clients under the age of 18*

_____ _____
Parent / Guardian Print Name Parent / Guardian Contact #