Myskincaregirl

Client Consultation Form and Health History

NAME _____ DATE of BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL_____

Sex: ___Female ___Male How were you referred to us?_____

Occupation: _____Does your job require that you work outdoors? __ No __Yes

What would you like to achieve from coming here?_____

_____

YOUR SKIN CARE

1) Have you ever had a facial treatment before? __No __Yes, when? _____

2) Have you ever had a body spa treatment before? __No __Yes

If yes, please specify when and what treatment: _____

3) Which of the following best describes your skin type? (Please check one)

__Type I Fair skin tones—Always burns, never tans

__Type II Light skin tones—Burns easily, tans slightly

__Type III Fair to olive skin tones—Burns moderately, tans moderately

__Type IV Light brown skin tones—Burns slightly, tans easily

__Type V Dark brown skin tones—Rarely burns, tans easily

__Type VI Dark brown to black skin tones—Never burns, tans easily

4) Do you have any special skin problems or concerns pertaining to your face or body? __No __Yes

If yes, please specify:_____

_____

5) Have you ever had dermaplaning, chemicals peels, laser treatments, or microdermabrasion? __No

__Yes In the last month? __No __Yes

6) Do you use Accutane, Retin-A, Renova, Adapalene Hydroxyl Acid or any other Retinol/vitamin A derivative products? __No __Yes

If yes, please specify what and when last used: _____

7) Have you used acne medication? __No __Yes, when? _____ Which medication? _____

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8) Have you experienced Botox, Restylane, or collagen injections? __No __Yes

If yes, please specify areas treated: _____

9) What skin care products are you currently using? (List brands if known)

Cleanser _____ Toner _____

Day Moisturizer _____ Night Moisturizer _____

Exfoliator _____ Mask _____

Eye Product _____ SPF/Sunscreen _____

Scrubs _____ Makeup Products_____

Soap _____ Shower Gels _____

Body Lotions _____ Other _____

10) Have you used any hair removal methods in the past six weeks? __No __Yes (Check all that apply)
___Shaving ___Waxing ___Electrolysis ___Plucking ___Tweezing ___Stringing
___Depilatories ___Other: _____

11) Do you experience irritation from shaving? __No __Yes

If yes, please specify: _____

12) Do you experience ingrown hairs as a result of hair removal? __No __Yes

13) What areas of concern do you have regarding your: Skin (Check all that apply) __Breakouts/acne __Uneven skin tone __Blackheads/whiteheads __Sun damage __Excessive oil/shine __Wrinkles/fine lines __Rosacea __Dull/dry skin __Broken capillaries __ Flaky skin __Redness/ruddiness __Dehydrated __Sun/liver/brown spots __Other: _____

Eyes (Check all that apply) __Dehydrated __Wrinkles __Puffiness __Dark circles __Other: _____

Lips (Check all the apply) __Dehydrated __Cracked/chapped lips __Other: _____

14) Have you ever had an allergic reaction to any of the following (Check all that apply)

If yes, please specify: _____
__Cosmetics __AHAs __Medication __Fragrance __Food __Shellfish __Animals __Latex __Sunscreens __Drugs __Iodine __Pollen __Other: _____

15) What SPF do you use on your face? _____ How often/when?_____

16) Have you recently used any self-tanning lotions, creams, or treatments? __No __Yes

If yes, please specify: _____

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17) Have you had any recent tanning bed or sun exposure that changed the color of your skin? __No __Yes If yes, please specify:

_____

HEALTH HISTORY

18) Are you taking any oral contraceptives? __No __Yes

If yes, please specify: _____

19) Have you experienced any recent changes to or from your contraceptives? __No __Yes

If yes, please specify what and when: _____

20) Are you pregnant or trying to become pregnant? __No __Yes

21) Are you experiencing hormonal or any menopausal symptoms? __No __Yes

If yes, please specify: _____

22) Are you currently undergoing any hormone therapy treatments? __No __Yes

If yes, please specify: _____

23) Have you ever experiences thyroid or other autoimmune disorders? __No __Yes

If yes, please specify:_____

24) Do you have a personal or family history of skin cancer? __No __Yes

If yes, please explain:_____

25) Have you ever been diagnosed with any other health disorder? __No __Yes

If yes, please specify what and when: _____

LIFESTYLE

26) How many glasses of water do you drink per day? (Please check one) __ <1 glass __ 1-3 glasses

__ 4-7 glasses __8+ glasses

27) How many caffeinated beverages (coffee, tea, soda, etc.) do you consume per day? (Please check one) __None __1-2 drinks __3-5 drinks __6+ drinks

28) How many alcoholic beverages do you consume per week? (Please check one) __I don't drink

__1-3 drinks __4-7 drinks __8+ drinks

29) How many hours of sleep do you get per night? (Please check one) __<3 hours __3-5 hours __6-8 hours __8-10 hours __10+ hours

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30) Which foods do you consume on a regular basis? __Fruits __Vegetables __Dairy/Eggs __Cheese __Poultry __Fish __Grains/Bread __Processed Sugar __Processed Meats

31) What does your daily commute look like? __Car __Bike __Public Transport __Walk __I don't commute

32) How often do you travel on a plane? __Never __1-2 times per year __1-2 times per quarter __Every month __Every week

33) How many hours do you spend in front of a screen or digital device? __<3 hours __ 4-6 hours __7-9 hours __10-12 hours __12+ hours

34) Do you exercise on a regular basis? __No __ Yes

35) Do you smoke cigarettes, vape, or consume other tobacco products? __ No __Yes

36) What are your stress levels on a scale from 1 to 5 (1 = low stress, 5 = high stress)? _____

FUTURE APPOINTMENTS/CONTACT

May I call you at the provided phone number to confirm future appointments? __No __Yes

May I contact you via mail/email about future promotions and news? __No __Yes

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release Stephanie Czech/ My Skin Care Girl LLC or any other known affiliations from liability and assume full responsibility thereof from this day forward.

Client Name (Printed):

_____

Client Name (Signature): _____ Date: _____

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Chemical Peel Consent

I, _____, have read the below information and initialed each section to indicate that I fully understand what to expect. If I have any questions or concerns, I will address these with my skin therapist. I give permission to my skin therapist, Stephanie Czech to perform any of the chemical treatments we have discussed and will hold her harmless from any liability that may result from these treatments. I understand my skin therapist will take every precaution to minimize or eliminate negative reactions such as blisters, sores, or other reactions, as much as possible. I do understand that, very rarely, permanent damage occurs. I have given an accurate account of any over-the-counter or prescription medications that I use regularly, and I am not presently using (nor have I used within the last year) isotretinoin (Accutane), Retin-A, Acyclovir or tranquilizers. I have not had any facial surgical procedures, piercings, tattoos, permanent cosmetics, or other chemical peels or skin treatments that I have not disclosed to my skin therapist. I am not ingesting or using topically any other over-the-counter product or prescription medication/agent that has not been disclosed to my skin therapist. I am not presently pregnant or lactating and I am over the age of eighteen (18). I have not had any recent radioactive or chemotherapy treatments, sunburn, wind burn or broken skin. I have not recently waxed or used a depilatory (such as Nair) on the area to be treated. I do not have a history of keloidal scarring, diabetes, any auto immune disease, active herpes blisters, or any other existing condition that may interfere with the positive outcome of this treatment. Initial here:_____

I understand that I should not have a chemical peel if I intend to continue to have excessive sun exposure, knowing that the treated area will be more sensitive to the sun as a result of the treatment and will require regular use of sunscreen. Initial here:_____

I consent to the taking of photographs to monitor treatment effects, as desired or recommended by my therapist. Initial here:_____

My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be required. The rate of improvement of my skin depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels, or acne condition. Initial here: _____

I understand that this procedure is expected to make the skin feel uncomfortable while being applied, but agree to inform the skin professional immediately if I have concerns or am overly uncomfortable during treatment or after I return home. Initial here:_____

I agree that I am willing to follow recommendations by my therapist for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I agree to use a moisturizer specifically recommended by my therapist and I acknowledge that I have been informed of the possible negative reactions (intense erythema, welts, scabs) and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately. Initial here:_____

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations. I agree that this constitutes full disclosure. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold Stephanie Czech/My Skin Care Girl LLC or any known affiliations liable (including for any of my conditions that were present, but not disclosed at the time of this procedure) from this day forward.

Client Name (printed) _____

Client Name (signature) _____Date_____

Esthetician _____Stephanie Czech_____

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Dermaplaning Consent Form

I, _____, have read the information and initialed each section to indicate that I fully understand what to expect. If I have any questions or concerns, I will address these with my skin therapist. I give permission to my therapist, Stephanie Czech, to perform the dermaplaning procedure we have discussed and hold them harmless from any liability that may result from this treatment. I understand he/she will take every precaution to minimize or eliminate negative reactions such as cuts, sores, or other reactions, as much as possible. I have given an accurate account of any over-the-counter or prescription medications that I use regularly and I am not presently using isotretinoin (Accutane). I have not had any facial surgical procedures or other chemical peels or skin treatments that I have not disclosed to my therapist. I am not ingesting or using topically any other over the-counter product or prescription medication/agent that has not been disclosed to my therapist. I am over the age of eighteen (18). I have not had any recent radioactive or chemotherapy treatments, sunburn, windburn, or broken skin. I have not recently waxed or used a depilatory (such as Nair) on the area to be treated. I do not have a history of keloidal scarring, excessive telangiectasia, rosacea, bacterial skin infections, fungal infections, viral infections, open lesions or rashes, active acne, any auto immune disease, or any other existing condition that may interfere with the positive outcome of this treatment. Initial here:_____

I am aware that Dermaplaning is a form of manual exfoliation similar in theory to microdermabrasion but without the use of suction or abrasive crystals. A stainless steel sterile blade is stroked along the skin at an angle to gently shave off dead skin cells from the epidermis which may cause minor superficial abrasions which may not appear until a day or two following treatment. Redness, excessive dryness, or even some peeling after treatment can also occur Initial Here:_____

Dermaplaning temporarily removes the fine vellus hair of the face, leaving a very smooth surface. It is an effective, non-invasive exfoliation treatment that allows home care products or other treatments to be more effective and increases penetration and absorption which could lead to other side effects. Initial here:_____

My expectations are realistic and I understand that the results are not guaranteed. The rate of improvement of my skin depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels, or acne condition. Initial here: _____

I understand that I should not have dermaplaning I if I intend to continue to have excessive sun exposure knowing that the treated area will be more sensitive as a result of the treatment and does require regular use of sunscreen. Initial here:_____

I consent to the taking of photographs to monitor treatment effects as desired by my therapist. Initial here:_____

I agree that I am willing to follow recommendations by my esthetician for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions, as well as avoiding vigorous activity that could leave me excessively red. I acknowledge that I have been informed of the possible negative reactions and the expected sequence of the healing process (dryness, irritation, redness, and abrasions of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately. Initial here:_____

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations. I agree that this constitutes full disclosure. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. The treatments I receive here are voluntary and I release Stephanie Czech/ My Skin Care Girl LLC or any other known affiliations from liability and assume full responsibility thereof from this day forward.

Client Name:_____

Client Signature _____Date:_____

Esthetician:_____Stephanie Czech_____

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Microdermabrasion Consent Form

I, _____, have read the information and initialed each section to indicate that I fully understand what to expect. If I have any questions or concerns, I will address these with my skin therapist. I give permission to my therapist, Stephanie Czech, to perform the microdermabrasion procedure we have discussed and hold them harmless from any liability that may result from this treatment. I understand he/she will take every precaution to minimize or eliminate negative reactions such as blisters, sores, or other reactions, as much as possible. I have given an accurate account of any over-the-counter or prescription medications that I use regularly and I am not presently using isotretinoin (Accutane). I have not had any facial surgical procedures or other chemical peels or skin treatments that I have not disclosed to my therapist. I am not ingesting or using topically any other over the-counter product or prescription medication/agent that has not been disclosed to my therapist. I am over the age of eighteen (18). I have not had any recent radioactive or chemotherapy treatments, sunburn, windburn, or broken skin. I have not recently waxed or used a depilatory (such as Nair) on the area to be treated. I do not have a history of keloidal scarring, excessive telangiectasia, rosacea, bacterial skin infections, fungal infections, viral infections, open lesions or rashes, active acne, any auto immune disease, or any other existing condition that may interfere with the positive outcome of this treatment. Initial here:_____

I understand I should not have microdermabrasion if I intend to continue to have excessive sun exposure, knowing that the treated area may be more sensitive to the sun as a result of the treatment and will require the use of daily sunscreen. Initial here:_____

I consent to the taking of photographs to monitor treatment effects, as desired or recommended by my therapist.

My expectations are realistic and I understand that the results are not guaranteed. Initial here:_____

I agree that I am willing to follow recommendations by my esthetician for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I acknowledge that I have been informed of the possible negative reactions and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately. Initial here:_____

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations. I agree that this constitutes full disclosure. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. The treatments I receive here are voluntary and I release Stephanie Czech/ My Skin Care Girl LLC or any other known affiliations from liability and assume full responsibility thereof from this day forward.

Client Name (printed) _____

Client Name (signature) _____ Date_____

Esthetician:_____Stephanie Czech_____

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LED LIGHT CONSENT FORM

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your LED treatment, please be aware of the following information and possible risks. Please initial:

___ I understand there are certain contraindications that would preclude me from receiving LED treatments, including epilepsy, medications causing light sensitivity, open wounds, pregnancy, and thyroid conditions.

___ I understand there are other precautions that should be considered before receiving LED therapy treatments and may require a doctor's release and/or I assume any risk involved.

___ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

___ I understand that some clients report slight tingling sensations and flashing of the optic nerve during the procedure.

___ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

___ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

___ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have any concerns, I will address these with my skin care specialist. I give permission to my skin care specialist to perform the LED procedure we have discussed, and will hold them or their staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold Stephanie Czech/My Skin Care Girl LLC or any known affiliations liable (including for any of my conditions that were present, but not disclosed at the time of this procedure) from this day forward.

Client Name (Printed) _____

Client Name (Signature) _____Date:_____

Skin care specialist_____Stephanie Czech _____

Associated Skin Care Professionals member