# Spa La La

Brows • Skincare • Massage

*3425 Bee Cave Rd. Suite B2 West Lake Hills, TX 78746  512-273-3700*

## *Skin History and Consent*

**Name** _____ **D.O.B** ____/____/____

**City/State/Zip** _____ **Occupation** _____

**Phone** (  ) - _____ **Referred by** _____

**DO YOU HAVE ANY MEDICAL CONDITIONS? (CHECK ALL THAT APPLY)**

[ ] Heart Problems [ ] Hormonal Problems [ ] High/Low Blood Pressure [ ] Diabetes [ ] Skin Cancer [ ] Allergies (list)

| | YES | NO |
|---|---|---|
| ARE YOU PREGNANT OR LACTATING? | [ ] | [ ] |
| DO YOU HAVE ROSACEA? *If so, for what?* | [ ] | [ ] |
| DO YOU GET COLD SORES/FEVER BLISTERS ON FACE/LIPS? *If yes, how often?* | [ ] | [ ] |
| DO YOU HAVE ANY IMPLANTS? *Pacemaker, pins in bones, etc.* | [ ] | [ ] |
| DO YOU WEAR CONTACT LENSES? | [ ] | [ ] |
| ANY RECENT SURGERIES? *If yes, please explain:* | [ ] | [ ] |
| ARE YOU TAKING ACCUTANE? | [ ] | [ ] |
| ARE YOU USING RETINOIDS? *If so, which ones?* | [ ] | [ ] |
| ARE YOU USING TOPICAL MEDICATIONS? *If so, which ones?* | [ ] | [ ] |
| ARE YOU USING EXFOLIATING ACIDS? *If so, which ones?* | [ ] | [ ] |
| ARE YOU TAKING ANY OTHER MEDICATIONS? *If so, which ones?* | [ ] | [ ] |
| HAVE YOU HAD AN ADVERSE REACTION TO A PRODUCT? *If so, which product or ingredient gave you the reaction?* | [ ] | [ ] |
| HAVE YOU HAD TREATMENT FROM A DERMATOLOGIST? *If so, for what condition(s)?* | [ ] | [ ] |

WHEN WAS THE LAST TIME YOU RECEIVED A FACIAL? _____

WHAT PRODUCTS/BRANDS ARE YOU USING?

CLEANSER: _____

[ ] SOAP [ ] GEL [ ] CREAM/MILKY [ ] **OTHER** _____

TONER/ASTRINGENT _____

FACIAL SCRUBS _____

SUNSCREEN _____ SPF # _____

ARE YOU HAPPY WITH THE RESULTS? _____

DESCRIBE YOUR HISTORY OF SUN EXPOSURE: _____

HOW DO YOU WANT TO IMPROVE YOUR SKIN? PLEASE LIST SPECIFIC AREAS YOU WANT TO TREAT. **FACE, NECK, CHEST, HANDS, OTHER**

ALLERGIES TO: [ ] LAVENDER [ ] ALOE VERA [ ] SHEA BUTTER

NOTES: _____

If you have a specific medical condition or symptoms, certain esthetic treatments may be contraindicated and a referral from your primary care physician will be required prior to services being rendered. If I experience any discomfort during the session, I will immediately inform the esthetician. Because some procedures relating to skincare such as peels, diamond dermabrasion, dermaplaning, & body treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all the questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile and understand that there shall be no liability on the esthetician's part should I fail to do so. I am authorizing ***Spa La La*** and the esthetician, to perform facial services/body treatments. I relieve ***Spa La La*** from any liability resulting from an adverse reaction to any of the services provided.

Client Printed Name _____ Date _____

Client Signature _____ Date _____

Esthetician Signature _____ Date _____