one life balance, inc.
Natural Health Center

Client Consultation—Esthetician

Name: _____ Date: _____

Address:_____ City: _____ State: _____ Zip Code:_____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Emergency Contact: _____

Your Health

- □ Cancer
- □ Hormone imbalance
- □ Systemic disease
- □ High blood pressure
- □ Spinal injury
- □ Thyroid condition
- □ Hysterectomy
- □ Diabetes
- □ Heart problem
- □ Varicose veins
- □ Arthritis
- □ Asthma
- □ Eczema
- □ Epilepsy
- □ Seizure
- □ Fever blisters
- □ Headaches (chronic)
- □ Hepatitis
- □ Herpes
- □ Frequent cold sores
- □ Immune disorders
- □ HIV/AIDS
- □ Lupus
- □ Metal bone pins or plates
- □ Phlebitis, blood clots, poor circulation
- □ Blood clotting abnormalities
- □ Psychological treatment
- □ Skin diseases/skin lesions
- □ Insomnia
- □ Sinus Problems
- □ Any active infection

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year? □ No □ Yes, please explain:_____

2) Have you had any of the following conditions in the past or present?
(Please check all that apply.)

3) Any recent surgery, including plastic surgery? □ No □ Yes

4) What would you consider you stress level? □ High □ Medium □ Low

5) Do you wear contact lenses? □ No □ Yes

6) Do you have any metal implants, metal dental work or wear a pacemaker? □ No □ Yes

7) Have you ever experienced claustrophobia ? □ No □ Yes

Your Skin Care

1) What would you like to achieve from your treatment today?_____
_____

2) Which of the following best describes your skin type? (please circle a roman numeral to the left)

I)	Creamy complexion	Always burns easily, never tans
II)	Light complexion	Always burns easily, tans slightly
III)	Light/Matte Complexion	Burns moderatly, tans gradually
IV)	Matte Complexion	Seldom burns, always tans well
V)	Brown Complexion	Rarely burns, deep tan
VI)	Black Complexion	Never burns, deeply pigmented

3) Do you have any special skin problems or concerns pertaining to your face or body?
Skin: (check all that apply)

- □ Breakouts/acne
- □ Blackheads/whiteheads
- □ Excessive oil/shine
- □ Rosacea
- □ Broken capillaries
- □ Redness/ruddiness
- □ Hyperpigmentation (darkening of skin)
- □ Hypopigmentation (lightening of skin)
- □ Keloids (thick or raised scars)
- □ Uneven skin tone
- □ Sun damage
- □ Wrinkles/fine lines
- □ Dull/dry skin
- □ Flaky skin
- □ Dehydrated
- □ Sun spots/liver spots
- □ Other_____

Eyes: □ Dehydrated □ Wrinkles □ Puffiness □ Dark circles □ Other:_____

Lips: □ Dehydrated □ Cracked or chapped □ Other:_____

4) Have you ever had chemical peels, laser or microdermabrasion? □ No □ Yes
In the last month □ No □ Yes

5) Do you use Retin-A, Renova, Adapalene Hydroxyl A Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/Vitamin A derivative products? □ No □ Yes
In the last 3 months? □ No □ Yes

6) Have you used an acne medication? □ No □ Yes
If yes, when and which drug(s)?_____

7) Have you recently used or had any self tanning lotions, creams or professional treatments?
□ No □ Yes, please specify:_____

8) Have you used any of the following hair removal methods in the past six weeks?
□ No □ Yes (circle all that apply)

Shaving Waxing Electrolysis Plucking Tweezing Threading Depilatories

9) Have you ever had an allergic reaction to any of the following? □ No □ Yes
If yes, please explain:_____

□	Cosmetics	□	AHAs
□	Medicine	□	Fragrance
□	Food	□	Shellfish
□	Animals	□	Latex
□	Sunscreen	□	Drugs
□	Iodine	□	Skin care products
□	Pollen	□	Other _____

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

11) What SPF do you use on your body? _____ How often/when? _____

12) Have you had any recent tanning bed or sun exposure that abnormally altered the color of your skin? □ No □ Yes, please specify:_____

13) Have you been exposed to the sun or used a tanning be in the last 48 hours? □ No □ Yes

14) How frequently are you exposed to the sun or use a tanning bed?
□ Infrequently □ Frequently □ Regularly

15) Have you experienced Botox, Collagen injections, Restylane, or any other fillers? □ No □ Yes, please specify:_____

16) What is your current facial skin care regiment?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Questions 17 – 22 concern only female clients:

17) Are you taking oral contraceptives? □ No □ Yes

18) Any recent changes to or from your contraceptive treatment? □ No □ Yes

19) Are you pregnant or trying to become pregnant? □ No □ Yes

20) Are you lactating? □ No □ Yes

21) Are you currently in menopause? □ No □ Yes
If so, have you experienced any related problems? □ No □ Yes

22) Are you undergoing any hormone replacement therapy? □ No □ Yes

Questions 23 & 24 concern only male clients:

23) What is your current shaving system? □ Wet shave □ Electric

24) Do you experience irritation from shaving? □ No □ Yes Ingrown hairs? □ No □ Yes

Future Appointments/Disclaimer:

May I call you at your home, work or cell 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 the 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 contradictions and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care form liability and assume full responsibility thereof.

Client Signature: _____ Date: _____