

EFFLEURAGE STUDIO

Facial | Wax | Lash

CONSULTATION CHART Name_ _____ State _____ Zip Code _____ Address ____ Telephone ______ Email _ _____ Birthdate _____ Date of Consultation _____ How did you hear of us? M F \square Occupation _ CLIENT HISTORY - WE CAN ACHIEVE YOUR GOALS ONLY IF YOU ARE HONEST WITH YOUR ANSWERS 12. Have you ever had ☐ Chemical Peel ☐ Microdermabrasion 1. Are you now or within the last year under a 7. Do you have any special concerns pertaining ☐ Rotox ☐ IPL (Photo Facial) physician's care? Dermatologist? Plastic Surgeon? to your body? ☐ Yes ☐ No ☐ Yes ☐ No □ Laser Hair Removal □ Laser Resurfacing If yes, specify_ If yes, specify_ ☐ Facial Filler (e.g. Restaylane/Collagen) 2. Have you undergone any surgery in the last 8. Do you: FEMALE CLIENTS ONLY nine months? smoke ☐ Yes □ No ☐ Yes ☐ No use Retin-A Are you taking oral contraception? ☐ Yes □ No ☐ Yes ☐ No If yes, specify _ ever use Accutane ☐ Yes □ No follow a restricted diet ☐ Yes □ No 2. Are you or now trying to become pregnant? 3. Have you had any of these health problems □ No exercise regularly ☐ Yes past or present? have regular sleep ☐ Yes ☐ No □ Breast feeding? ☐ Hormone Imbalance ☐ No ☐ Cancer patterns □ Diabetes ☐ Hysterectomy have chemically MALE CLIENTS ONLY □ No □ Epilepsy ☐ Thyroid lightened hair ☐ Yes 1. What is your current shaving system? ☐ Heart Problem □ Varicose Veins wear contact lenses ☐ Yes □ No ☐ Wet ☐ Electric ☐ Facial Warts ☐ HIV or AIDS ☐ STDs □ Drug Addiction 9. What types of skin care products are you 2. Do you ever experience irritation from shaving? ☐ Hepatitis ☐ Cold Sores currently using daily? ☐ Yes ☐ No ☐ soap/cleanser ☐ toner ☐ serums 4. List any medications and vitamins that you scrub ☐ moisturizer ☐ sunblock 3. Do you experience ingrown hairs? take regularly: □ acne spot treatment □ skin bleacher ☐ Yes ☐ No Indicate WEEKLY use of: 4. Do you wish you could get a closer shave? ☐ scrub/peel/microdermabrasion cream condition(s): ☐ masque: _ ☐ Yes ☐ No □ other OIL SECRETION 5. Do you have permanent make-up? ☐ Yes ☐ No 1. Do you experience breakthrough oily shine 10. Have you ever had a facial treatment before? If yes, where _ ☐ Yes ☐ No during the day? ☐ Yes ☐ No If yes, specify_ 6. Do you have any special skin problems or concerns pertaining to your face? 2. Do you experience skin break-outs? 11. Have you ever had plastic surgery? ☐ Yes ☐ No ☐ Yes ☐ No ☐ Occasionally ☐ Yes ☐ No If yes, specify If yes, specify_ MOISTURE HYDRATION 1. How many glasses of plain water do you ESTHETICIAN COMMENTS consume daily? □ None □ 1-3 □ 4-7 □ 8 or more 2. How many alcoholic beverages do you consume weekly? □ None □ 1-3 ☐ 4 or more 3. Do you ever experience any of the following conditions on your skin? ☐ Flakiness ☐ Tightness ☐ Obvious dryness 4. Do you use a sunscreen/sunblock? □ Always □ Sometimes □ Never ☐ Only when I go outside

What SPF do you use?_

CAPILLARY ACTIVITY 1. Do you burn easily in moderate sunlight? ☐ Yes ☐ No 2. Do you blush easily when nervous?	NERVE ACTIVITY 1. How many cups of caffeine-type beverages (coffee, tea, soft drinks) do you drink daily? ☐ None ☐ 1-3 ☐ 4 or more	QUESTIONS TO UPDATE EACH VISIT 1. Are you currently having or due for your menstrual period? Yes No
☐ Yes ☐ No	What level do you consider your pain threshold to be?	Have you started any new medications? Yes □ No If yes, specify
3. When/if drinking alcohol, do your cheeks turn red? Yes	□ Low	I confirm to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment Client Signature:
	EFFLEURAGE STUDIO Facial Wax Lash (OFFICE USE ONLY)	
AM	RECOMMENDED REGIMEN PM	Weekly VMD
OTHER RECOMM	MENDED TREATMENTS	TODAY'S DATE
OTHER RECOMM	MENDED TREATMENTS	TODAY'S DATE
OTHER RECOMM	MENDED TREATMENTS	TODAY'S DATE
OTHER RECOMM	MENDED TREATMENTS	TODAY'S DATE
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