



FACIAL TREATMENT

CLIENT CONSULTATION FORM

Please fill out this form on your first appointment. Your answer will better help us to meet your needs and ensure that you have a happy and satisfying experience.

CLIENT INFORMATION

Name: Tia Bernabela Date: Oct 23 2023

Date of birth: Aug 16 2000 Age: 23 Female Male NB

Address: 170 Chalkfarm drive

City: Waltham State: MA Zip: 02451

Phone: 647 512 7211 Email: Tia Bernabela

Your Occupation: _____

Emergency contact: Claudia Adams Phone #: 647-770-7949

Would you like to be added to our email list for news and exclusive offers? Yes No

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- | | | |
|--|--|---|
| <input checked="" type="checkbox"/> Acne | <input type="checkbox"/> Herpes | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Metal bone pins/plates |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Phlebitis, blood clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyper pigmentation | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypo pigmentation | <input type="checkbox"/> Skin disease/lesions |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Seborrhea |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Warts |

Any other condition: _____

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Any known allergies? No Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin: _____

Any recent surgery, including plastic surgery? No Yes, explain: LIP0 360

♀ Are you pregnant or trying to become pregnant? No Yes

Have you ever had a facial treatment before? No Yes

If yes, please explain: _____

What would you like to achieve from your treatment today?

taking out my black heads.

SKIN CARE

Please Check Current Products You Use:

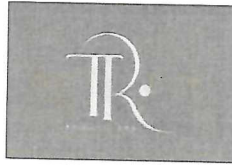
- | | | |
|---|---|--|
| Eye Make-Up Remover | Eye Cream | Mask |
| Cleansing Cream <input checked="" type="checkbox"/> | Day Cream <input checked="" type="checkbox"/> | Facial Scrub <input checked="" type="checkbox"/> |
| Facial Soap <input checked="" type="checkbox"/> | Night Cream | Exfoliants |
| Skin Toner/ Astringent | Neck lotion | Body Lotion |
| Body Soap | Hand cream | Body Scrub |

SKIN HISTORY

- | | | | | | |
|--------------------------------------|--------|---|--------------------------------------|---|-----------|
| What is your skin type? | Normal | <input checked="" type="radio"/> Oily | Dry | <input checked="" type="radio"/> Combo | Unsure |
| Your exposure to the sun? | | <input type="radio"/> Never | Light | <input checked="" type="radio"/> Moderate | Excessive |
| What type of foundation do you wear? | | <input checked="" type="radio"/> Liquid | Cream | <input type="radio"/> Powder | None |
| How does your skin heal? | | <input checked="" type="radio"/> Fast | Slow | <input type="radio"/> Scars | Pigments |
| Do you get bruises easily? | | <input type="radio"/> No | <input checked="" type="radio"/> Yes | | |

SKIN CONCERNS

- | | | | |
|---|--|---|---------------|
| <input checked="" type="checkbox"/> Acne | Dryness/Dull Skin | Milia | Sensitivity |
| <input checked="" type="checkbox"/> Blackheads | Eczema | <input checked="" type="checkbox"/> Oily Skin | Sun Damage |
| Broken Capillaries | Fine lines/Wrinkles | Psoriasis | Thin Skin |
| Comedones | <input checked="" type="checkbox"/> Hyper pigmentation | Redness | Unwanted Hair |
| Cherry Angioma | <input checked="" type="checkbox"/> Hypo pigmentation | Rosacea | Other: _____ |
| <input checked="" type="checkbox"/> Discoloration | Keloids | <input checked="" type="checkbox"/> Scarring | |



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I hereby consent to and authorize Tia Bernabela to perform the following procedure: facial Treatment

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by:

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Client Name (printed)

Client Name (signature)

Oct 23 2023

Date

Esthetician (signature)

Date