



## Client Evaluation Card & Consent for Microdermabrasion/Peel Treatments

Name: \_\_\_\_\_

By completing this client profile, you will assist us in evaluating your skin condition. The information you provide will be used to determine what factors may be affecting your skin so that we may recommend the proper care.

Date: \_\_\_\_\_ Consultation By: \_\_\_\_\_

Address: \_\_\_\_\_

Best Phone #: \_\_\_\_\_ Do you prefer texting for contact...YES or NO....

Age Group: Under 30 / 30-40 / 40-50 / 50-60 / 60

### + Lifestyle

How many hours do you sleep per night? .....

How often do you exercise? .....

On a scale from 1 (low) to 10 (high), how would you rate your stress level?.....

Do you practice any mindfulness or meditation practices on a daily or weekly basis?

Would you like support with creating healthy lifestyle habits & Wellness?

### Nutrition

Check any of the following foods that you consume regularly

<input type="checkbox"/> Sugar: _____	<input type="checkbox"/> Spicy Foods: _____	<input type="checkbox"/> Dairy Products: _____
<input type="checkbox"/> Salty Foods: _____	<input type="checkbox"/> Snack Foods: _____	<input type="checkbox"/> Meat Products: _____

Check the types of fluids that you consume daily and indicate the quantities:

<input type="checkbox"/> Water: _____	<input type="checkbox"/> Juices: _____	<input type="checkbox"/> Tea: _____
<input type="checkbox"/> Coffee: _____	<input type="checkbox"/> Alcohol: _____	<input type="checkbox"/> Colas: _____

### Health/Medical

Please list all medications that you take regularly that may affect your skin's sensitivity or cause your skin to become reactive. Include hormones, vitamins, etc.:

.....  
Please check any health conditions which you have had or are now experiencing:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Muscular Conditions	<input type="checkbox"/> Dermal Fillers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Botox®
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hormonal Disorders	<input type="checkbox"/> Metal implants, screws	<input type="checkbox"/> Smoking
<input type="checkbox"/> Claustrophobia	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Pregnancy -or-	<input type="checkbox"/> Sugar Diabetes
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Recent Pregnancy	<input type="checkbox"/> Thrombosis or Phlebitis
<input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Lack of Normal Skin Sensation	<input type="checkbox"/> Recent Surgery	<input type="checkbox"/> Thyroid Disorders
		<input type="checkbox"/> Recent Illness	<input type="checkbox"/> Whiplash

Comments



Skin Care for life inside and out

## Health/Medical, cont.

Have you ever undergone treatment from a dermatologist? ☐ Yes ☐ No

If yes, when? .....

What type of condition? .....

Any negative side effects? .....

Within the last month, have you taken or used any of the following?

☐ Retin-A

☐ Antibiotics

☐ Diuretics

☐ Accutane

☐ Oral Contraceptives

☐ Laxatives

Have you ever undergone plastic surgery? .....

When? .....

Where on your body? .....

What information can you provide about the procedure? .....

## Home Skin Care Regimen

Describe in detail (using product brand names) exactly how you are presently caring for your skin:

.....

## What are your concerns?

What is your specific concern about your skin? .....

.....

How long have you noticed your condition? .....

Is this an ongoing or temporary condition? .....

Have you ever received a salon skin care treatment? .....

What were the results? .....

How did you hear about us? .....

## Client Release

*Caution: Do not perform microcurrent or vacuum massage if any of the following conditions exist: any severe health conditions or any of the following contraindications, Epilepsy, Pacemaker, Pregnancy, Thrombosis or Phlebitis, or if the conditions are unknown to you consult a physician.*

*Caution: Do not perform microdermabrasion applications if any of the following conditions exist: Severe health conditions or any of the following contraindications, any contagious disease, any drug causing sun sensitivity (Tetracycline), any drug or application causing thinning of skin (Retin-A or Accutane), blood transmitted diseases (HIV, Hepatitis, Herpes), Hemophilia, or if the conditions are unknown to you, consult a physician. PLEASE STOP ALL RETIN-A PRODUCTS 10 DAYS PRIOR TO YOUR TREATMENT.*

*Caution: Do not perform light rejuvenation applications if any of the following conditions exist: Severe health conditions or any of the following contraindications Hypersensitivity to light or "photo allergy," tendency toward photo-toxic reactions, taking of photo-sensitizing or photo-toxic medication, cancer, epilepsy, pregnancy, or if the conditions are unknown to you, consult a physician.*

I certify that the above statements are true and correct, and that I, ....., having been advised and fully informed by ..... of ..... concerning the nature of the process proposed, to be performed by them, and hereby authorize and direct them to perform such process and perform such services as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1) I have read, understand and fully agree to the foregoing (2) Give consent to the proposed process that has been satisfactorily explained to me and I have all the information that I desire (3) I hereby give my consent and authorization voluntarily and release the establishment and its agents of any claims that I have or may have in the future in connection with the described application.

**Signature** ..... **Date** ..... **Interviewer** ..... **Date** .....