



Skincare Health History Form

Name: _____

Address: _____

City _____ State _____ Zip Code _____

Daytime Contact # _____ Evening Contact # _____

Would you like to receive notification of future promotions & specials? **Yes** **No** Email _____

Occupation _____ Significant Other _____

Birthday _____ Anniversary Date _____

Incase of Emergency, Please notify... Name _____ Telephone # _____

How did you hear of Warm Touch Body Spa?

Referral _____ (Did you know you get \$10 spa dollars as a THANK YOU for each referral)

Yellow Pages **YOU Magazine** **Sign on Window** **Gift Certificate/Card**

Advertisement _____ **Website** _____ **Other** _____

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

Do you have any special skin problems or concerns pertaining to your face? _____

Have you ever had a facial treatment before? Yes No How long ago? _____ How often? _____

Have you ever had chemical peels before? Yes No How long ago? _____ How often? _____

Have you ever had laser or microdermabrasion before? Yes No How long ago? _____ How often? _____

Do you **currently** use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? Yes No

Describe: _____

Have you in the **past 3 months** used Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/Vitamin A derivative products? Yes No

Do you **currently** use a prescribed acne medication? Yes No

Have you in the **past 3 months** used a prescribed acne medication? Yes No

What type of skin care products are you currently using?

Cleanser Yes No _____

Toner Yes No _____

Scrub Yes No _____

Mask Yes No _____

Moisturizer Yes No _____

Eye Product Yes No _____

Serums Yes No _____

Soap Yes No _____

Shower Gel Yes No _____

Body Lotions Yes No _____

Sunscreen Yes No _____

Other Yes No _____

Makeup Products Yes No _____

Areas of concern regarding your **Skin**:

Breakouts/Acne Redness/Ruddiness Fine Lines

Blackheads/Whiteheads Uneven Skin Tone Dull/Dry Skin

Excessive Oil/Shine Sun Spots/Liver Spots Flaky Skin

Rosacea Sun Damage Dehydrated

Broken Capillaries Deep Wrinkles

Other _____

Areas of concern regarding your **Eyes**: Dehydrated Wrinkles Puffiness Dark Circles Other

Skincare Health History Form continued...

I have read the above information and if I had any concerns, I have addressed them or will address them before my service with my esthetician. I give permission to my therapist to perform the skin care procedure we have discussed and will hold her harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I am willing to follow the recommendations made by my esthetician for a home care regimen that will increase the benefits of the skin care procedure for my skin care concerns. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. 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 Signature

Date

Esthetician Signature

Date