Organic Facial Treatment

Name: ______________________________ Date: ______________________

Address: ____________________________ Apt # ________ City/Prov __________ Postal code ____________

Telephone: Home: _________________ Cell: ____________________ Work: ___________________

Email: ______________________________ Can we add you to our seasonal mailing list? Yes___ No___

Do you prefer to be contacted by phone ________ email _____ or either _____

Date of birth: ________________ Occupation: _______________________

Physician/Dermatologist: ___________________________ Address: _____________________________________

Referred by:

☐ Friend	☐ Walk-by	☐ Mailer	☐ Internet search	Other:

Are you currently receiving treatment from another health care professional? (eg. Chiropractor, Naturopath, Acupuncture, Physiotherapy, Dermatologist)
____

Emergency Contact: Name: ____________________________ Phone number: ______________________

Medications (oral & topical): ____

Supplements: ____

Allergies:

☐ Sulfur	☐ Blueberries	☐ Pineapple	☐ Ragweed	Other:
☐ Essential oils	☐ Algae	☐ Papaya	☐ Salicylic acid	
☐ Strawberries	☐ Seaweed	☐ Nuts	☐ Aloe Vera	

Is this your first facial? Yes ___ No ___
What is the reason for your visit today?
____
____
What special areas of concern do you have?
____
____
Are you presently under a physician's care for any current skin condition or other problem? Yes ___ No ___ What?____________
Are you pregnant? Yes ___ No ___
Are you taking birth control pills? Yes ___ No ___
Hormone Replacement? Yes ___ No ___
Do you wear contact lenses? Yes ___ No ___
Do you smoke? Yes ___ No ___
Do you often experience stress? Yes ___ No ___
Have you had skin cancer? Yes ___ No ___

Are you using (or used in the past): Azelex ___ Differin ___ Renova ___
Retin A ___ Tazarac ___ Glycolic or Alpha Hydroxy Acids ___
If so, when and for how long?
____
Are you now using or have you ever used Accutane? Yes____ No ___
If so, when and for how long? ___________________________
Do you have acne? Yes ___ No ___
Experience frequent blemishes? Yes ___ No___
If so, how frequently?
____
Have you had botox? Yes ___ No ___
If yes, what area(s)? ___________________________
Last botox treatment date ___________________________
What products do you use presently?

- ☐ Soap
- ☐ Cleanser (Gel or Cream)
- ☐ Toner
- ☐ Scrub/exfoliant
- ☐ Mask
- ☐ Creams
- ☐ Sunscreen

Other: ________________________________

CLIENT'S CONSENT TO TREATMENT

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the therapist to stop or alter the treatment or clarify the reason for a therapeutic technique being used.

Date: ________________________________ Signature: ____