BLUE
HUNTSVILLE
MEDSPA | COSMETIC SURGERY

Name: _____ Phone Number: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ Male/ Female: _____
Referred by: _____ E-mail: _____ @ _____
In case of emergency: _____ Phone Number: _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, facials may be contraindicated. A referral from your primary care provider may be required prior to the service being provided. Circle Yes or No as it applies. If you answer "yes" to any of the following questions, please explain as clearly as possible.

Health

Yes/No Within the last year have you been under a dermatologists or other physician's care?

Yes/No Within the last nine months, have you undergone any surgery?

Yes/No Do you smoke?

Yes/No Do you exercise regularly?

Yes/No Do you follow a restricted diet?

Yes/No Do you wear contact lenses?

Yes/No Do you have metal implants, a pacemaker or body piercing?

Your Skin

Yes/No Do you have any special skin problems pertaining to your face or body? _____

What skin care products are you currently using?

Face: Soap/ Cleanser/ Toner/ Moisturizer/ Mask/ Exfoliator/ Eye Products

Body: Soap/ Scrub/ Oil/ Body Moisturizer/ Depilatories/ Self Tanner

Exfoliation History

Yes/No Have you ever had a chemical peel, microdermabrasion, or any other resurfacing treatment?

Yes/No Do you use Accutane, Retin A, Renova, Adapalene, Tazorac? In the last 3 months?

Yes/No Are you currently using any products that contain the following ingredients? Glycolic Acid/ Lactic Acid/ Exfoliating Scrub/ Hydroxy Acid/ Vitamin A Derivatives (i.e. Retinol)

Moisture Hydration

How much plain water do you consume daily? _____

How many alcoholic beverages do you consume? _____

Do you experience these conditions on your skin? Flakiness/ Tightness/ Obvious Dryness

What SPF sunscreen do you use on your face? _____ Body? _____

Capillary Activity

Yes/No Do you burn easily in moderate sunlight?

Yes/No Do you blush easily when nervous?

Yes/No Do you have a tendency to redness?

Yes/No Do you suffer from sinus problems?

Oil Secretion

Yes/No/Occasionally Do you ever experience oily shine during the day?

Yes/No/Occasionally Do you ever experience breakouts?

Nerve Activity

Light/Medium/High What is your pain threshold?

Yes/No Have you ever experienced claustrophobia?

Have you ever had a reaction to any of the following? Cosmetics/ Medicine/ Iodine/ Pollen/ Food/ Hydroxy Acids/ Animals/ Fragrance/ Sunscreen/ Latex Other? _____ What are your skin care goals?

_____

I understand that the facial I receive is provided for the basic purpose of relaxation and cleansing. If I experience any pain or discomfort during this session I will immediately inform the practitioner so that the pressure and/ or products may be adjusted to my level of comfort. I further understand that facials should not be construed as a substitute for a medical examination, diagnosis or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that facial practitioners are not qualified to diagnose, prescribe or treat any physical or mental illness and that nothing said in the course of a session given should be construed as such. Because a facial should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's and Asante Spa's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client Signature: _____Date: _____
Practitioner Signature: _____Date: _____

Consent to treatment of a minor Under 18: By my signature below, I hereby authorize Blue Medspa Huntsville to administer facial techniques to my child as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____