Consultation Card

Name: ____

Address: ____________________________City:__________ State:_____ Zip Code:________

Phone:_(______)____________________ Work: _(______)______________________________

Email Address: ____

May we contact you via mail/email about future promotions and news? □ Yes □ No

How did you hear about us? ____

Birthday:__________________________ □ under 21 □ 21 – 30 □ 31 – 40 □ 41-50 □ 51-60 □ 60+
If under 18, please provide your age ________

Your health:

1. Within the last year, have you been under a dermatologist's or other physician's care? □ yes □ no
   if yes, please explain____
   ____
2. Within the last nine months, have you undergone any surgery? □ yes □ no
   if yes, please specify____
3. Have you had any heath problems in the past or present? □ yes □ no
   if yes, please specify____
4. List any medications, supplements, vitamins, diuretics, slimming tablets etc. that you take regularly. ____
   ____
5. Do you smoke? □ yes □ no
6. Do you exercise regularly? □ yes □ no
7. Do you follow a restricted diet? □ yes □ no
8. Do you wear contact lenses? □ yes □ no
9. Do you have metal implants, a pacemaker or body piercings? □ yes □ no
10. Rate your level of stress on a scale of 1 to 4 (1=low stress, 4=high stress) _____________

Your Skin:

11. Do you have any special skin problems pertaining to your face or body? □ yes □ no
    if yes, please specify____
12. What skin care products are you currently using?
    Face: □ soap □ cleanser □ toner □ moisturizer □ masque □ exfoliator
    □ eye products

    Body: □ soap □ shower gel □ scrubs □ oil □ body moisturizer
    □ depilatory product □ self tanners

Exfoliation history:

13. Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments?
□ yes □ no In the last month? □ yes □ no
14. Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products? □ yes □ no In the last 3 months? □ yes □ no
15. Are you currently using any products that contain the following ingredients?
□ glycolic acid □ lactic acid □ any exfoliating scrubs □ any hydroxy acid product
□ vitamin A derivatives (i.e. retinol)

Moisture hydration:

16. How much plain water do you consume daily?
____
17. How many alcoholic beverages do you consume weekly?
____
18. Do you ever experience these conditions on your skin? □ flakiness □ tightness □ obvious dryness
19. What SPF sunscreen do you use on your face? ____________________ Body?
____
20. Do you sunbathe or use tanning beds? □ yes □ no

Capillary activity:

21. Do you burn easily in moderate sunlight? □ yes □ no
22. Do you blush easily when nervous? □ yes □ no
23. Do you have a tendency to redness? □ yes □ no
24. Do you suffer from sinus problems? □ yes □ no

Oil secretion:

25. Do you ever experience oily shine during the day? □ yes □ no □ occasionally
26. Do you ever experience skin breakouts? □ yes □ no □ occasionally

Nerve activity:

27. Do you drink more than 4 caffeinated beverages daily? (coffee, tea, soft drinks)
□ yes □ no
28. Do you ever experience a burning, itching sensation on your skin? □ yes □ no
29. What is your pain threshold? □ low □ medium □ high
30. Have your ever experienced claustrophobia? □ yes □ no
31. What type of massage pressure do you prefer? □ light □ medium □ firm
32. Have you ever had a reaction to any of the following?
□ cosmetics □ medicine □ iodine □ pollen □ food □ hydroxy acids □ animals
□ fragrance □ sunscreens □ other____

Female clients only:

33. Are you taking oral contraception? □ yes □ no
34. Are you pregnant or trying to become pregnant? □ yes □ no
35. Are you lactating □ yes □ no

Male clients only:

36. What is your current shaving system? □ electric □ wet shave
37. Do you experience irritation from shaving? □ yes □ no
38. Do you experience ingrown hairs? □ yes □ no

Questions to discuss every visit:

39. Are you currently having or due for your menstrual period? □ yes □ no
40. Have you started any new medication since your last visit? □ yes □ no
41. Have you had any recent dental x-rays? □ yes □ no
42. What are your skin care goals?

____

____

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment. I am aware that there are often inherent risks associated with skin care services and that the services I am about to receive could have unfavorable results including but not limited to allergic reaction, irritation, burning, redness, scarring, soreness, etc. By signing below, I further agree that I will not hold Amb Day Spa, or its affiliates, or any of its employees responsible should there be any unfavorable outcome or result.

____

Client signature **date**

____

if under 18 Parent's signature **date**

This consultation card is to correctly evaluate your special skin care needs. This information is confidential and may be disclosed only to staff members, risk or quality improvement personnel to assess the quality of care and will not be passed on to a third party.

Thank you for visiting Amb Day Spa!

I confirm (to the best of my knowledge) that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Signature: ____Date: __________________

Signature: ____Date: __________________

Signature: ____Date: __________________

Signature: ____Date: __________________

Signature: ____Date: __________________

Signature: ____Date: __________________

Treatment / Product Record

Date	Treatment/Products used in the treatment/contraindications/notes	Product recommendations/ Samples given	Other