Skin Consultation Form

the spa | acac

Name: _____ Date of Birth: _____

Date: _____ **acac** Member: **Yes** **No**

Address: _____

Email: _____

Home phone: _____ Cell phone: _____

Referred by: _____

Emergency contact name and phone number: _____

Would you like to be notified by email of spa specials, events and promotions? **Yes** **No**

Healthy History

Within the lst year, have you been under a dermatologist's or other physician's care? **Yes** **No**

Please list any injuries, surgeries or health conditions: _____

_____

Do you smoke? **Yes** **No** Are you diabetic? **Yes** **No**

Do you wear contacts? **Yes** **No** Do you use sun block? **Yes** **No**

Do you have metal implants, a pacemaker or body piercings? **Yes** **No**

Do you have any skin conditions on your face or body such as psoriasis or eczema? **Yes** **No**

If yes, please specify: _____

Have you ever had chemical peels, microdermabrasion, or any resurfacing treatments? **Yes** **No**

If yes, please indicate when: _____

Do you have a tendency to redness? **Yes** **No**

Do you ever experience oily shine during the date? **Yes** **No**

Are you pregnant? **Yes** **No** If yes, which trimester? _____

Are you currently using blood thinners? **Yes** **No**

If yes, please list: _____

Please list any known allergies: _____

Please list any medications you are currently taking, including vitamins, supplements, etc.:

_____

What skin care products are you currently using? (please circle)

Soap	Cleanser	Exfoliator
Moisturizer	Masque	Prescription products -
Eye products	Toner	please list:

Do you ever experience the following? (please circle)

Flakiness Tightness Obvioius dryness

What are your skin care goals? _____

_____

Please circle any of the following that apply to you:

Broken skin Fragile capillaries Active herpes cold sores

Waxing Information

Have you ever had any adverse reactions to waxing? **Yes** **No**

If yes, please explain: _____

When did you last shave?_____ How often do you shave?_____

Do you have any tendencies to any of the following (circle all that apply)

Ingrown hair
Hyperpigmentation
Scarring
Bruising
Bumps/hives

Please circle if you are currently using or have used any of the following products within the last 3 months:

Acutane
Glycolic Acid
Retin-A
Pro-Active skincare
Daily dose(s) of Aspirin
Any form of Vitamin C
Renova

I have read the information on the reverse side and recorded my medical history accurately with all pertinent information. For future services, I agree to inform my spa technician of any changes in my medical status and/or the above information. I agree to hold acac and its employees harmless for the performances of these services. I understand spa services are not to be considered medical treatment, and as such, the spa technician cannot prescribe treatment of pharmaceuticals.

Cancellation policy: In order to provide optimal scheduling for all clients and to fairly compensate out therapist, acac finds it necessary to implement a 24-hour cancellation policy for all spa appointments. Payment in full is expected for any appointment missed or called within 24 hours of the scheduled session. We appreciate your understanding and cooperation.

I understand that any comments or behavior deemed inappropriate by the service provider (illicit or sexually suggestive in nature) will result in the immediate termination of the session and I will be liable for payment of the scheduled service.

_____ _____

Signature (if under 18, parent/legal guardian must sign) Date