Guest Consultation Form for Skin Care - Facials

Please Print Legibly

Guest Name:_______________________________ Date:________________
Address:__________________________________ Birth-date:_____________
City, State, Zip:____________________________ Phone:________________
Email:_____________________________________ May we add you to our email list? Y/N
Cell Phone #________________________

How did you hear about us?___________________

AGE: Under 20 20-30 30-40 40-50 50-60 60+

Guest Information:

Within the last year have you been under a dermatologist's care?_________________
Within the last six months have you undergone any facial plastic surgery? _________
If yes, please specify:____
Are there any medications, supplements, vitamins, or diuretics that you take regularly? (please list):____
Are you pregnant?____
Have you ever had a professional facial or skin care treatment? __________________
If yes, when?____
What are your skin care goals?____
Do you suffer from any of the following illnesses or diseases?

Lupus	Topical Steroids	Photosensitive Med
Cancer	Bleeding Disorders	Hormonal Med
Keloid Scars	Clotting Disorders	Herbal Remedies
Hypo-pigmentation	Systemic Diseases	Cold Sores
Diabetes	Cardiac Disease	Migraine
Roacutanne	Hyper-pigmentation	Active Tan
Skin Disorders	Hormonal Imbalance	Poly-cystic Ovaries
Epilepsy	Eczema	Psoriasis
Lumps/Cysts		

Have you used/are you using Rx products/medications? (Roaccutane, Birth Control pills or Hormones)____

Have you/are you using Retin A? ____
Are you allergic to latex? (If yes, please elaborate on the severity of previous reactions)
____
Do you have any other allergies/intolerances to foodstuffs, drugs, chemicals, etc?
____

Describe your skin (choose all that apply):

Normal	Uneven/Blotchy	Acne
Cystic	Oily	Mature
Milia	Sallow	Combination

Wrinkled	Blackheads	Pigmented
T-Zone	Saggy	Occasional Breakouts
Oily	Dry	Firm
Rosacea	Freckled	Large Pores
Scarred	Sun-damaged	Small Pores
Melasma		

What problems do you have with your skin?____
What products are you using at the moment?_______________________________________
What would you like to see improved with your skin?________________________________
What is your daily skin care routine?____
Do you use a high quality sunscreen/sunblock daily or regularly?_______________________
How much sun exposure have you had in the past? Extreme Moderate Rarely
Do you or have you in the past used sunbeds? Never Sometimes Regularly
How do you rate your health at the moment?____
Do you smoke?_______________________ How many a day?__________________________
Do you drink alcohol?________________ How many glasses a week? _________________
How would you rate your diet/eating habits?____

GUEST RELEASE

I confirm to the best of my knowledge that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or results thereof. I am aware that there are inherent risks associated with skin/massage care services and bodywork. The services I am about to receive could have contraindications which could result in allergic reaction, irritation, burning, redness, soreness, etc. By signing below, I further agree that I will not hold Royal Pampering Day Spa or its affiliates or any of its employees responsible should there be any unfavorable outcome or result.
Please note that all guests are considered late 15 minutes after the appointment time. It may be necessary to reschedule your appointment. We require a 24 hour cancellation notice or service appointment fee will be charged.

Signature ______________________________ Date _______________________

Parent or Guardian Signature _________________________________ Date ________________
(if under 18)

Would you like to receive our exclusive text message alerts? Yes or No
STD MSG/DATA RATES MAY APPLY

Therapist Signature ____ Date ________________