



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:

<input type="checkbox"/> Friend	<input type="checkbox"/> Walk-by	<input type="checkbox"/> Mailer	<input type="checkbox"/> Internet search	Other: _____
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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:

<input type="checkbox"/> Sulfur	<input type="checkbox"/> Blueberries	<input type="checkbox"/> Pineapple	<input type="checkbox"/> Ragweed	Other: _____
<input type="checkbox"/> Essential oils	<input type="checkbox"/> Algae	<input type="checkbox"/> Papaya	<input type="checkbox"/> Salicylic acid	
<input type="checkbox"/> Strawberries	<input type="checkbox"/> Seaweed	<input type="checkbox"/> Nuts	<input type="checkbox"/> Aloe Vera	

<p>1. Is this your first facial? Yes ___ No ___</p> <p>2. What is the reason for your visit today?</p> <p>_____</p> <p>_____</p> <p>3. What special areas of concern do you have?</p> <p>_____</p> <p>_____</p> <p>4. Are you presently under a physician's care for any current skin condition or other problem? Yes ___ No ___ What? _____</p> <p>5. Are you pregnant? Yes ___ No ___</p> <p>6. Are you taking birth control pills? Yes ___ No ___</p> <p>7. Hormone Replacement? Yes ___ No ___</p> <p>8. Do you wear contact lenses? Yes ___ No ___</p> <p>9. Do you smoke? Yes ___ No ___</p> <p>10. Do you often experience stress? Yes ___ No ___</p> <p>11. Have you had skin cancer? Yes ___ No ___</p>	<p>12. Are you using (or used in the past): Azelex ___ Differin ___ Renova ___ Retin A ___ Tazarac ___ Glycolic or Alpha Hydroxy Acids ___</p> <p>If so, when and for how long? _____</p> <p>13. Are you now using or have you ever used Accutane? Yes ___ No ___</p> <p>If so, when and for how long? _____</p> <p>14. Do you have acne? Yes ___ No ___</p> <p>Experience frequent blemishes? Yes ___ No ___</p> <p>If so, how frequently? _____</p> <p>15. Have you had botox? Yes ___ No ___</p> <p>If yes, what area(s)? _____</p> <p>Last botox treatment date _____</p> <p>16. What products do you use presently?</p> <p><input type="checkbox"/> Soap</p> <p><input type="checkbox"/> Cleanser (Gel or Cream)</p> <p><input type="checkbox"/> Toner</p> <p><input type="checkbox"/> Scrub/exfoliant</p> <p><input type="checkbox"/> Mask</p> <p><input type="checkbox"/> Creams</p> <p><input type="checkbox"/> Sunscreen</p> <p>Other: _____</p>
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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: _____