



## 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	

<ol style="list-style-type: none"> <li>1. Is this your first facial? Yes ___ No ___</li> <li>2. What is the reason for your visit today? _____</li> <li>3. What special areas of concern do you have? _____</li> <li>4. Are you presently under a physician's care for any current skin condition or other problem? Yes ___ No ___ What? _____</li> <li>5. Are you pregnant? Yes ___ No ___</li> <li>6. Are you taking birth control pills? Yes ___ No ___</li> <li>7. Hormone Replacement? Yes ___ No ___</li> <li>8. Do you wear contact lenses? Yes ___ No ___</li> <li>9. Do you smoke? Yes ___ No ___</li> <li>10. Do you often experience stress? Yes ___ No ___</li> <li>11. Have you had skin cancer? Yes ___ No ___</li> </ol>	<ol style="list-style-type: none"> <li>12. Are you using (or used in the past): Azelex ___ Differin ___ Renova ___ Retin A ___ Tazarac ___ Glycolic or Alpha Hydroxy Acids ___ If so, when and for how long? _____</li> <li>13. Are you now using or have you ever used Accutane? Yes ___ No ___ Is so, when and for how long? _____</li> <li>14. Do you have acne? Yes ___ No ___ Experience frequent blemishes? Yes ___ No ___ If so, how frequently? _____</li> <li>15. Have you had botox? Yes ___ No ___ If yes, what area(s)? _____ Last botox treatment date _____</li> <li>16. What products do you use presently?               <ul style="list-style-type: none"> <li><input type="checkbox"/> Soap</li> <li><input type="checkbox"/> Cleanser (Gel or Cream)</li> <li><input type="checkbox"/> Toner</li> <li><input type="checkbox"/> Scrub/exfoliant</li> <li><input type="checkbox"/> Mask</li> <li><input type="checkbox"/> Creams</li> <li><input type="checkbox"/> Sunscreen</li> </ul>               Other: _____             </li> </ol>
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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: \_\_\_\_\_