CLIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION

First Name: ___________________________ Last Name: __________________________ Today's Date: _________________

Address: ____ Date of Birth: _________________

City: _________________________________ State: ________________________________ Zip: ___________________________

Phone Number: ______________________ E-mail: ______________________________ Occupation: __________________

Emergency Contact: Name: ____ Phone: _______________________

How did you find me? ____________________________ If referred, by whom? ____________________________________

SKIN HISTORY

Have you ever had a facial or body treatment before? ☐ No ☐ Yes

If yes, when and what treatment: ____

What areas of concern do you have regarding your skin? (Check all that apply)

☐ Dehydrated ☐ Flaky ☐ Redness ☐ Uneven Tone

☐ Rough ☐ Acne/Breakouts ☐ Large Pores ☐ Normal

☐ Dry/Dull ☐ Broken Capillaries ☐ Sensitivity ☐ Oily/Shiny

☐ Sun Damaged ☐ Dark Circles ☐ Scarred ☐ Under Eye Puffiness

☐ Wrinkles/Fine Lines ☐ Crows Feet ☐ Discoloration ☐ Rosacea

What is your current skin care routine? (Check all that apply)

☐ Cleanser ☐ Serum ☐ Makeup ☐ Mask

☐ Toner ☐ Lotion ☐ Shower Gel ☐ Soap & Water Only

☐ Moisturizer ☐ Eye Product ☐ Exfoliation ☐ Daily Sunscreen

Any specific product line you like to use? ____

Have you used an acne medication? ☐ No ☐ Yes, when? _____________ Which one(s)? ______________________

Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Retinol or Vitamin A derivative products? ☐ No ☐ Yes

If yes, please describe: ____

Have you used any of the products above in the last 3 months? ☐ No ☐ Yes

Have you ever had an adverse reaction to any skin care treatment or product? ☐ No ☐ Yes

If yes, please explain: ____

Have you ever had eczema or psoriasis? ☐ No ☐ Yes (Circle which one)

Do you have a personal or family history of skin cancer? ☐ No ☐ Yes, relationship to you? ____________________

HEALTH HISTORY

Have you had any of the following health conditions in the past or present? (Check all that apply)

☐ High Blood Pressure	☐ Lupus	☐ Cold Sores	☐ Blood Clotting Issues
☐ Low Blood Pressure	☐ Epilepsy	☐ Chronic Headaches	☐ Sinus Problems
☐ Spinal Injury	☐ Herpes	☐ Nervous Condition	☐ Asthma
☐ Thyroid: Hyper	☐ Hepatitis B	☐ Poor circulation	☐ Sunburn
☐ Thyroid: Hypo	☐ Hepatitis C	☐ Skin Disease/Lesions	☐ Claustrophobia
☐ Hysterectomy	☐ HIV/AIDS	☐ Fever	☐ Oedema
☐ Diabetes	☐ Mononucleosis	☐ Cold/Flu	☐ Osteoporosis
☐ Heart Problems	☐ Tuberculosis	☐ Kidney Problems	☐ Cuts/Bruises
☐ Arthritis/Nerve Pain	☐ Hormone Imbalance	☐ Cancer	☐ Psychological Condition
☐ Varicose Veins	☐ Seizure Disorder	☐ Slipped Disc	

Provide additional information or any condition I have not listed: ____

____

Have you ever had an allergic reaction to any of the following? (Circle all that apply)

Medicine Food Animals Sunscreens Iodine Pollen AHAs Fragrance Shellfish Latex Drugs Cosmetics Other: ______________________

Please explain in further detail: ____

____

Have you been under the care of a dermatologist or other medical professional in the last year? □ No □ Yes

If yes, please where and for what: ____

List any medications including prescriptions, over-the-counter, or supplements (multivitamins, herbal, etc.) you take regularly:

____

____

Do you have any metal implants or wear a pacemaker? □ No □ Yes

Have you ever been treated for cancer? □ No □ Yes, please describe therapies used:

____

Have you had any recent surgery, including plastic surgery, Botox, and dermal fillers (in the last 2-6 months)?

□ No □ If yes, when and where on your body? ____

Do you follow a restricted diet? □ No □ Yes, describe ____

What is your stress level? □ High □ Medium □ Low

Do you smoke? □ No □ Yes

Wear contact lenses? □ No □ Yes

Exercise regularly? □ No □ Yes

Do you have any piercings or tattoos (including permanent/semi-permanent makeup)? □ No □ Yes

If yes, where are they located? ____

How many cups of water do you drink per day? ________ cups Coffee? ________ cups Alcohol? ________ cups

How many hours of sleep do you get a night? □ 1-3 hours □ 4-6 hours □ 7-9 hours □ 10 hours +

FEMALE CLIENTS ONLY

Do you take birth control? □ No □ Yes

Are you pregnant or trying to conceive? □ No □ Yes

Are you lactating? □ No □ Yes

Are you menopausal? □ No □ Yes

MALE CLIENTS ONLY

Experienced shaving irritation? □ No □ Yes

Do you get ingrown hairs frequently? □ No □ Yes

Current shaving system? □ Wet Shave □ Electric

CONSENT FOR TREATMENT

I understand all questions asked on these forms, and I have answered truthfully and honestly to the best of my knowledge. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I fully understand that the services offered are not a substitute for medical care and treatment. I am aware that individual results are dependent upon my age, skin conditions, and lifestyle. I agree to actively participate in following all appointment scheduled and home care procedures to the best of my ability, so that I may obtain maximum results. In the event that I may have additional questions or concerns regarding my treatments or suggested home care routine, I will consult with my esthetician immediately.

The esthetician reserves the right to refuse service to anyone for any reason.

All client information is confidential, unless written consent is given by the client to allow disclosure to third-party.

The treatments are voluntary and I release and hold harmless the licensed esthetician, AliciaDion Beauty, and the institution, AliciaDion Beauty LLC. ®, from any liability for any and all adverse reactions, which may result from any treatment.

By signing below, I acknowledge that I have read and fully understand the information listed above.

Client Name (Printed): ____ Date: ______________

Client Name (Signature): ____ Date: ______________

Esthetician (Signature): ____ Date: ______________

FUTURE APPOINTMENTS/CONTACT

What is the best method to contact you about your future appointments? □ Call □ Text □ Email

May I contact you via mail/email/text about future promotions? □ No □ Yes, which one? ______________

Drop your usernames ☺ : FB: _______________ Instagram: _______________ SC: _______________

ACKNOWLEDGEMENT OF POLICIES

By signing below, I acknowledge that I have read and fully understand all of the following policies on the AliciaDion Beauty. ® website in its entirety:

1. DEPOSIT POLICY — Client Initials ________
2. LATE ARRIVAL POLICY — Client Initials ________
3. RESCHEDULE/LATE CANCEL POLICY — Client Initials ________
4. NO CALL/NO SHOW POLICY — Client Initials ________
5. NEW AND EXISTING MEDICAL CONDITION POLICY — Client Initials ________
6. REFUND POLICY — Client Initials ________
7. CHILDREN POLICY — Client Initials ________

Client Name (Printed): ____

Client Name (Signature): ____ Date: _________________

Esthetician (Signature): ____ Date: _________________