Essentials
MASSAGE AND FACIALS

SKIN HISTORY FORM

Patient Name: _____ D.O.B: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Family Physician: _____ Preferred Contact Method: _____

Age: _____ Email: _____

PLEASE CHECK THE FEATURES THAT BEST DESCRIBE YOUR SKIN:

This information is necessary for us to design a treatment plan specifically for you.

Sun Damage		Brown Spots/Freckles		Blackheads		Oily	
Whiteheads		Clogged Pores		Sensitive		Dull	
Chronic Acne		Fine Lines		Normal		Broken Capillaries	
Scarring		Dry patches		Wrinkles		Loss of Elasticity	

What skincare products are you currently using?: _____

Are you under a doctor or other healthcare practitioner's care? **Y / N**

When was your last facial/ Skin care service? Date and Service **(Include at home treatments):** _____

_____

Are you currently taking medications? **Y / N** If yes, Please list: _____

Are you taking any antibiotics oral-topical? **Y / N** If yes, Please list: _____

Do you have any allergies to medications, cosmetics, latex, nickel, sulfur, bi-sulphites? **Y / N**

Please list any and all allergies: _____

Have you ever been prescribed Accutane® or Retina-A®? **Y / N**

Have you used waxes or depilatories? **Y / N**

If yes, How Recently? Which areas?: _____

Do you use daily sun protection? **Y / N**

Do you have a history of cold sores? (Herpes Simplex) **Y / N** If yes, How Frequently?: _____

Do you Smoke? **Y / N**

Do you have epilepsy? Or other health issue we should be aware of? **Y / N**

If yes, please list: _____

Do you have a pacemaker, internal heart defibrillator or metal implants in your body? **Y / N**

Have you ever had cosmetic treatments such as Botox, Fillers, or Cosmetic Surgery? **Y / N**

If yes, When?: _____ Which areas?: _____

For Women: Pregnant **Y / N** Hormone Imbalance: **Y / N** Birth Control: **Y / N**

Cancellation Policy: I agree to cancel 24 hours in advance. Unless there is an emergency, if I miss one appointment without notice, I agree to pay the full appointment fee.

I give consent to receive treatment at Essentials Massage & Facials. I understand I will be receiving a professional service from a licensed skincare specialist. I will provide my skincare specialist with as much background as possible to assure I will receive maximum results. I understand that any esthetician at Essentials will not diagnose illness, disease, or any other physical or mental disorder. I also agree there will be no liability on the Practioner's part or Essentials LLC for any services rendered.

CLIENT SIGNATURE: _____ DATE: _____