The Seventh Moon
WELLNESS SPA

Facial Client Consultation & Skin Analysis Chart

Please Print Legibly

Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Email _____ Phone _____

Cell Phone Service Provider (if you want to receive text messages) Circle one: AT & T T- Mobile Verizon Other _____

Please take a moment to carefully read the following information and sign where indicated.

Have you ever had a professional facial treatment before? ☐Yes ☐No How recently? _____

What are your goals? _____

List current medications: _____

Do you have diabetes? ☐ Yes ☐ No Do you have cardiac/circulatory problems? ☐ Yes ☐ No

Which of the following best describes your skin type? (Please circle one type number.)

I	Creamy complexion	Always burns easily, never tans
II	Light complexion	Always burns, tans slightly
III	Light/Matte complexion	Burns moderately, tans gradually
IV	Matte complexion	Seldom burns, always tans well
V	Brown complexion	Rarely burns, deep tan
VI	Black complexion	Never burns, deeply pigmented

Have you ever had chemical peels, laser, or microdermabrasion? ☐ Yes ☐ No Within the last month? ☐ Yes ☐ No

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

Have you experienced Botox, Restylane, or Collagen injections? ☐ Yes ☐ No If yes, explain: _____

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

Have you used an acne medication? ☐ Yes ☐ No If yes, please specify: _____

Have you had any allergic reactions to the following? If yes, check and explain:

_____

☐ Cosmetics ☐ Sunscreens ☐ Latex
☐ Medicine ☐ Fragrance ☐ Shellfish / Iodine
☐ Food ☐ Alpha Hydroxy Acids ☐ Drugs
☐ Animals ☐ Pollen ☐ Other: _____

What skin care products do you use? Please list the brand when know.

☐ Soap/Cleanser _____ ☐ Eye Product _____ ☐ Night Moisturizer/Cream _____
☐ Exfoliator/Scrub _____ ☐ Day Moisturizer _____ ☐ Other: _____
☐ Mask _____ ☐ Sunscreen _____ ☐ _____
☐ Toner _____ ☐ SPF? _____ ☐ _____

What areas of concern do you have regarding your skin? Please check all that apply.

☐ Breakouts/Acne ☐ Broken capillaries ☐ Sun damage
☐ Blackheads/Whiteheads ☐ Redness/ruddiness ☐ Wrinkles/fine lines
☐ Excessive oil/shine ☐ Sun spot/liver spot/brown spot ☐ Dull/dry skin
☐ Rosacea ☐ Uneven skin tone ☐ Other: _____
☐ Flaky skin ☐ Dehydrated skin _____

I understand, I have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

For consumer information contact: State Board of Cosmetology, PO Box 2649, Harrisburg, PA 17105-2649
Phone: 717-783-7130 Fax: 717-705-5540 Email: ST-cosmetology@pa.gov

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

Consent to Treatment of Minor: By my signature, I hereby authorize the practitioner to administer esthetic services to my child or dependent, as they deem necessary.

Signature of Parent or Guardian: _____ Date: _____

Recommendations

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