BEYOND TRANQUILITY SPA
10411 Reserve Drive, San Diego, CA 92127
858-829-1776

SKIN HISTORY and CONSENT FORM

Name ____________________ **D.O.B** ____________________

Address ____________________ **City** ____________________ **State** __________

Zip __________ **Mobile** ( ) - __________ **Home** ( ) - __________

Occupation ____________________ **Referred by** ____________________

Email ______________________________

DO YOU HAVE ANY HEALTH PROBLEMS? (CHECK ALL THAT APPLY)

Heart Problems Hormonal Problems High/Low Blood Pressure Diabetes Skin Cancer Allergies (list) ____________________

	YES	NO
ARE YOU PREGNANT OR LACTATING?		
DO YOU HAVE ROSACEA? *If so, for what?*		
DO YOU GET COLD SORES/FEVER BLISTERS ON FACE/LIPS? *If yes, how often?*		
DO YOU HAVE ANY IMPLANTS? *Pacemaker, pins in bones, etc.*		
DO YOU WEAR CONTACT LENSES?		
ANY RECENT SURGERIES? *If yes, please explain:*		
ARE YOU TAKING ACCUTANE?		
ARE YOU USING RETINOIDS? *If so, which ones?*		
ARE YOU USING TOPICAL MEDICATIONS? *If so, which ones?*		
ARE YOU USING EXFOLIATING ACIDS? *If so, which ones?*		
ARE YOU TAKING ANY OTHER MEDICATIONS? *If so, which ones?*		
HAVE YOU HAD AN ADVERSE REACTION TO A PRODUCT? *If so, which product or ingredient gave you the reaction?*		
HAVE YOU HAD TREATMENT FROM A DERMATOLOGIST? *If so, for what condition(s)?*		

WHEN WAS THE LAST TIME YOU RECEIVED A FACIAL? __________

WHAT PRODUCTS/BRANDS ARE YOU USING?

CLEANSER: ____________________

SOAP GEL CREAM/MILKY OTHER __________

TONER/ASTRINGENT ____________________

FACIAL SCRUBS ____________________

SUNSCREEN ______________ SPF # __________

ARE YOU HAPPY WITH THE RESULTS? __________

DESCRIBE YOUR HISTORY OF SUN EXPOSURE: __________

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HOW DO YOU WANT TO IMPROVE YOUR SKIN? PLEASE LIST SPECIFIC AREAS YOU WANT TO TREAT. **FACE, NECK, CHEST, HANDS, OTHER**

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ALLERGIES TO: LAVENDER ALOE VERA SHEA BUTTER

NOTES: ______________________________

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Please take a moment to carefully review the information you have provided. If you have a specific medical condition or specific symptoms, certain esthetic treatments may be contraindicated and a referral from your primary care physician will be required prior to services being rendered. I, the undersigned, understand that the services I am receiving are provided for the basic purpose of relaxation. If I experience any discomfort during the session, I will immediately inform the esthetician. Because some procedures relating to skincare such as peels, diamond dermabrasion, body treatments and wraps should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all the questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile and understand that there shall be no liability on the esthetician's part should I fail to do so. I am authorizing *Beyond Tranquility Spa* and the esthetician, to perform facial services/bodywraps. I relieve *Beyond Tranquility Spa* from any liability resulting from an adverse reaction to any of the services provided.

Client Printed Name ______________________________ Date ______________

Client Signature ______________________________ Date ______________

Esthetician Signature Date