



a DOCS affiliate

Client Information

Name _____

Address _____

City, State, Zip Code _____

Phone# _____ DOB _____

Email Address _____

Is this your first visit to our spa? _____

How were you recommended to us? _____

Have you ever had a facial treatment before? _____

Skin Type: Oily, Combination, Normal, Dry, Sensitive, Reactive

Main Concerns:

Acne _____
Acne Scarring _____
Enlarged Pores _____
Blackheads _____
Whiteheads _____

Aging _____
Fine Lines/Wrinkles _____
Deep Wrinkles _____
Tone/Texture _____
Pigmentation _____

Sun Damage _____
Rosacea _____
Broken Capillaries _____
Other _____

*Have you ever had a reaction to a cosmetic or skin care product? **No Yes**

If yes, please describe: _____

*Have you had SURGERY, Botox or Restylane within the last (6) months? **No Yes**

If yes, please describe: _____

*Do you have any other medical conditions that we should be aware of?

*Are you at this time taking any medication? **No Yes** _____

*Are you pregnant or breast feeding? **No Yes** _____

Client Signature _____ Date _____