



CLIENT BRIEF FORM
FACIAL & SKINCARE

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CLIENT INTAKE FORM

CLIENT INFORMATION

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ NB

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency contact: _____ Phone #: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? Yes ☐ No ☐

MEDICAL HISTORY

Do you have or have you had any of the following conditions? If yes, please select them:

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Herpes | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Metal bone pins/plates |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Phlebitis, blood clots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hyper pigmentation | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypo pigmentation | <input type="checkbox"/> Skin disease/lesions |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Seborrhea |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Keloid scarring | <input type="checkbox"/> Warts |

Any other condition: _____

Notes:

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Any known allergies? ☐ No ☐ Yes: _____

List any medications you take regularly, including vitamins, herbal supplements, aspirin:

Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain: _____

Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

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

If yes, please explain: _____

What would you like to achieve from your treatment today?

SKIN CARE

Please Check Current Products You Use:

- | | | |
|---|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Eye Make-Up Remover | <input type="checkbox"/> Eye Cream | <input type="checkbox"/> Mask |
| <input type="checkbox"/> Cleansing Cream | <input type="checkbox"/> Day Cream | <input type="checkbox"/> Facial Scrub |
| <input type="checkbox"/> Facial Soap | <input type="checkbox"/> Night Cream | <input type="checkbox"/> Exfoliants |
| <input type="checkbox"/> Skin Toner/ Astringent | <input type="checkbox"/> Neck lotion | <input type="checkbox"/> Body Lotion |
| <input type="checkbox"/> Body Soap | <input type="checkbox"/> Hand cream | <input type="checkbox"/> Body Scrub |

SKIN HISTORY

- What is your skin type? ☐ Normal ☐ Oily ☐ Dry ☐ Combo ☐ Unsure
- Your exposure to the sun? ☐ Never ☐ Light ☐ Moderate ☐ Excessive
- What type of foundation do you wear? ☐ Liquid ☐ Cream ☐ Powder ☐ None
- How does your skin heal? ☐ Fast ☐ Slow ☐ Scars ☐ Pigments
- Do you get bruises easily? ☐ No ☐ Yes

SKIN CONCERNS

- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dryness/Dull Skin | <input type="checkbox"/> Milia | <input type="checkbox"/> Sensitivity |
| <input type="checkbox"/> Blackheads | <input type="checkbox"/> Eczema | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Sun Damage |
| <input type="checkbox"/> Broken Capillaries | <input type="checkbox"/> Fine lines/Wrinkles | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Thin Skin |
| <input type="checkbox"/> Comedones | <input type="checkbox"/> Hyper pigmentation | <input type="checkbox"/> Redness | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Cherry Angioma | <input type="checkbox"/> Hypo pigmentation | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Discoloration | <input type="checkbox"/> Keloids | <input type="checkbox"/> Scarring | _____ |

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Have you ever used acne medication? ☐ No ☐ Yes

If yes, when? _____ Which drug? _____

Have you in the last 3 months used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products? ☐ No ☐ Yes, please describe: _____

Have you received Botox, Restylane, or Collagen injections in the last 6 months?
☐ No ☐ Yes, please describe: _____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition/s that would make the requested treatment unsuitable. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any misrepresentation of my health.

Esthetician (signature)

Client Name (signature)

Date

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CLIENT CONSENT FORM

I hereby consent to and authorize _____ to perform the following procedure: _____.

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by:

_____.

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

By signing below I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

This agreement will remain in effect for this procedure and all future follow-ups conducted by the technician. I understand that this consent agreement is legal and binding. I have read and fully understand all information in this agreement. I am over 18 years of age and consent to the agreement and to the brow lamination procedure, or if I am under 18 years of age, I have had my parent or legal guardian consent to this agreement, and his or her relationship to me is as follows:

By his or her signature below, he or she ratifies and consents to this procedure under these terms.

Esthetician (signature)

Client Name (signature)

Date

FACIAL & SKINCARE TREATMENT RECORD

CLIENT INFORMATION

Name: _____ Date: _____

Phone: _____ Mail: _____

SKIN ANALYSIS

Skin type:

☐ Normal ☐ Oily ☐ Dry ☐ Sensitive
☐ Combination

Pores:

☐ Fine ☐ Dilated ☐ Comedones ☐ Milia

Moisture content:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Elasticity:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Acne:

☐ No
☐ I ☐ II ☐ III ☐ IV

Skin sensitivity:

☐ Normal ☐ Sensitive ☐ Hyper sensitive

Fine lines (Glogau scale):

☐ I - None ☐ II - Wrinkles in motion
☐ III - Wrinkles at rest ☐ IV - Mostly wrinkles

FACIAL & SKINCARE TREATMENT RECORD



Known allergies:

Life style:

☐

Active

☐

Sedentary

Medications:

Previous treatments:

NOTES

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SKIN TYPE GUIDE



NORMAL

Balances, clear and not sensitive



SENSITIVE

May burn or itch after using certain cosmetics and skincare products.

Can also react with redness



COMBINATION

Drier in some places (mostly cheeks) and oil in others such as T-zone



DRY

Flaky, scaly or rough patches on the face and/or body



OIL

Shiny, greasy looking, most likely to have visible enlarged pores

FACIAL & SKINCARE CLIENT RECORD

[illegible]

DAILY PLANNER

DATE

/ /

GOALS

- ☐
- ☐
- ☐
- ☐
- ☐

TO DO LIST

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

TODAY'S APPOINTMENT

TIME:

EVENTS:

BREAKFAST:

LUNCH:

SNACK:

DINNER:

NOTES

MONTHLY CALENDAR

MONTH OF

	mon	tue	wed	thu	fri	sat	sun
WEEK 1							
WEEK 2							
WEEK 3							
WEEK 4							
WEEK 5							

GOALS

PRODUCT INVENTORY

[illegible]