



CLIENT BRIEF FORM  
**FACIAL & SKINCARE**

CLIENT NAME:

DOMEIRACHIRINOS.COM

# FACIAL & SKINCARE

## 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:

# FACIAL & SKINCARE

## CLIENT INTAKE FORM

Any known allergies? ☐ No ☐ Yes: \_\_\_\_\_

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

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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?

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### 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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## CLIENT INTAKE FORM

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*

# FACIAL & SKINCARE

## 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:

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Life style:

☐

Active

☐

Sedentary

Medications:

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Previous treatments:

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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]