Soleil
Wellness & Day Spa

Name: _____ Date of Birth: _____ Date: _____

Address:_____

Phone:_____ E-mail: _____

What would you like to achieve from your treatment today? _____

Your Skin Care

1. Have you ever had a facial treatment before? No Yes, when? _____

2. 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

3. Do you have any special skin problems or concerns pertaining to your face or body? Yes No

   Specify:_____

4. Have you ever had chemical peels, laser or microdermabrasion? No Yes In the last month? No Yes

5. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid or Retinol/vitamin A derivative products? No Yes

   Describe: _____

6. What skin care products are you currently using? (List brands below)

   Soap _____ Toner _____
   Mask _____ Eye Product _____
   Cleanser_____ Day Moisturizer_____
   Exfoliator _____ Scrubs _____
   BodyLotions_____ Sunscreen_____
   SPF_____ NightMoisturizer/Cream_____
   Other_____

7. Have you used acne medication? No Yes, When? _____

8. Have you recently used any self-tanning lotions, creams or treatments? No Yes, specify:_____

9. Have you used any of the following hair removal methods in the past six weeks? No Yes , circle all that apply.
   0 Shaving o Waxing 0 Electrolysis 0 Plucking 0 Tweezing

10. What areas of concern do you have regarding your Skin? (Please check any that apply and explain)

    o Breakouts/acne o Blackheads/whiteheads o Excessive oil/shine
    o Rosacea o Broken capillaries o Redness/ruddiness
    o Sun spot/liver spot/brown spot

11. Have you ever had an allergic reaction to any of the following? (Please check any that apply and explain)

    Explain: _____

    o Cosmetics o Medicine o Food o Sunscreens o Iodine o Pollen

    o AHAs o Fragrance o Shellfish o Latex o Drugs

    Other_____

12. What SPF do you use on your face? _____ How often/when? _____

13. Have you had any recent tanning bed or sun exposure that changed the color of your skin? No Yes

    Specify:_____

14. Have you experienced Botox, Restylane or Collagen injections? No Yes

    Specify:_____

Female Clients Only:

15. Are you taking oral contraceptives? No Yes Specify:_____
16. Are you pregnant or trying to become pregnant? No Yes
17. Are you lactating? No Yes
18. Any menopause problems? No Yes Specify:_____
19. Are you undergoing any hormone replacement therapy? No Yes Specify:_____

Future Appointments/Contact:

Preferred appointment confirmation: ____ Text ____ Email ____ phone call

I understand, 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 Soleil Wellness & Day Spa from liability and assume full responsibility thereof.

Client Signature: _____ Date:_____