Lotus Organics
DAY SPA & WELLNESS

CONFIDENTIAL CLIENT INFORMATION – SKINCARE

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone Number: (home) _____ (cell) _____ (work) _____

Email Address: _____ Would you like to receive occasional email updates? ☐ Yes ☐ No

How would you like to receive appointment reminders? ☐ Phone Call ☐ Phone Text ☐ Email ☐ None*
**Please note that failure to keep your appointment or cancel within 24 hours may result in additional fees. See Policies for details.*

Current Occupation/Employer: _____

How did you hear about us? ☐ Google ☐ Yelp ☐ Newspaper Ad ☐ Vehicle Advertisement
☐ From a friend, please provide his/her name: _____
☐ Other, please explain: _____

Have you ever received a professional skincare session? ☐ Yes ☐ No How recently? _____

What type of session did you receive? ☐ Relaxing Facial ☐ Acne/Deep Cleansing Facial ☐ Chemical Peel
☐ Anti-Aging Facial ☐ Microdermabrasion ☐ Light/Laser Therapy
☐ Other, please explain: _____
_____

THE FOLLOWING REQUIRED INFORMATION MUST BE COMPLETED IN ITS ENTIRETY, HONESTLY AND TO THE BEST OF YOUR KNOWLEDGE:

Please list all medications (over-the-counter *and* prescribed) and supplements that you are currently taking:
_____
_____

Please list all allergies or sensitivities, including smells: _____
_____

Do you have or have you recently been in contact with any contagious illnesses or infections, including skin conditions:
☐ No ☐ Yes, please explain: _____

Have you ingested any alcohol or illegal substances in the last 24 hours? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

LIFESTYLE/MEDICAL

What is your typical daily intake of:

Water?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Caffeine?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Salt?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Sugar?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Cigarettes?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Dairy?	☐ None	☐ Light	☐ Moderate	☐ Heavy
Spicy food?	☐ None	☐ Light	☐ Moderate	☐ Heavy

What is your ethic background? *(Used only to determine skin type and possible reactions.)* _____

PLEASE CONTINUE ON THE BACK OF THIS PAGE.

Please mark the box(es) next to any health condition below that applies to you now or has applied to you in the past:

☐ Anxiety/Panic Attack
☐ Asthma
☐ Blood clots
☐ Cancer
☐ Cardiac problems
☐ Claustrophobia
☐ Diabetes
☐ Fainting
☐ Headaches
☐ Heart Attack
☐ High Blood Pressure
☐ HIV/Aids
☐ Hormone Imbalance
☐ Infectious Skin Condition
☐ Jaw pain
☐ Migraines
☐ Menopause
☐ Neck Pain
☐ PMS
☐ Post-Traumatic Stress Disorder
☐ Pregnancy
☐ Seizures
☐ Stroke
☐ Thyroid disorder
☐ Other notable conditions not listed (*please list and describe below*)

Further explanation for any of the above conditions: _____

_____

_____

Do you have any of the following occurring today: ☐ Broken bones ☐ Cold/flu/fever ☐ Cold Sores
☐ Cuts/bruises/burns ☐ Headache ☐ Inflammation ☐ Skin rash ☐ Sunburn ☐ Warts

SKINCARE

Please list all products used regularly on the area to be treated today: _____

_____

Are you using or have you used any glycolic, salicylic, Retinol, or any doctor prescribed acne/anti-aging creams, gels, or medications (oral or topical)? ☐ Yes ☐ No *Please describe:* _____

Do you use a tanning bed or tan in the sun on a regular basis? ☐ Yes ☐ No Do you burn easily? ☐ Yes ☐ No

Do you blush/turn red easily? ☐ Yes ☐ No Do you have sensitivity to products? ☐ Yes ☐ No

What temperature of water do you use when cleansing your face? *Please circle.* **COLD WARM HOT**

Do you experience problems with any of the following? *(Please check all that apply.)*

❒ Tightness in skin ❒ Flaking skin ❒ Shiny/oily skin ❒ Scars ❒ Moles
❒ Hyperpigmentation/Dark Spots ❒ Acne breakouts/Blackheads (In what area of the face? _____
_____)

What are your specific concerns/goals for your skincare session(s)?

_____

_____

By providing my signature below, I confirm that the information recorded above is complete and accurate to the best of my knowledge. I understand that skincare therapy is not a replacement for prescribed medical treatment, and that the esthetician may only perform treatments within his or her scope of practice and level of comfort. Anything said during this session shall not be regarded as medical advice, treatment, diagnosis, or prescription. I understand that the esthetician may refuse service at any time for any reason, and that certain medical issues may contraindicate some skincare services and will be referred to a medical professional. I understand that it is my responsibility to inform the esthetician of any changes to my medical profile or skincare routine, and that the esthetician will not be held liable for anything resulting from my failure to do so. I agree that I have been given sufficient opportunity to ask questions and make specific requests in order to make my treatment time as comfortable as possible. I have also read and will abide by all policies and client expectations that are listed separately from this document.

Client Signature: _____ Date: _____
(☐ *Check here if you are signing as the legal guardian for a minor under the age of 18.*)

Therapist Signature: _____ Date: _____