skincare specialist
Daniela Hortencio

FACIAL TREATMENT CONSENT FORM

Date_____ Name _____ D.O.B. _____

phone # _____ email _____

ARE YOU PREGNANT? YES NO | ARE YOU NURSING? YES NO | DO YOU SMOKE? YES NO

DO YOU WEAR CONTACTS? YES NO | DO YOU WEAR SUNSCREEN REGULARLY? YES NO

HAVE YOU VISITED A TANNING BOOTH WITHIN THE LAST WEEK? YES NO

ARE YOU TAKING ANTIBIOTICS? YES NO

ARE YOU USING PRODUCTS CONTAINING? GLYCOLIC ACID or AHA IF SO, FOR HOW LONG? _____

HOW DOES YOUR SKIN REACT TO IT? _____

ARE YOU USING ACCUTANCE? YES NO IF SO, FOR HOW LONG? _____

HAVE YOU EVER USED HYDROQUINONE (SKIN LIGHTENER)? YES NO IF SO, FOR HOW LONG? _____

DO YOU CURRENTLY USE WAX, ELECTROLYSIS OR DEPILATORIES ON YOUR FACE? YES NO

IF SO, WHEN WAS YOUR LAST TREATMENT? _____

HAVE YOU HAD ANY OF THE FOLLOWING:

MICRODERMABRASION? YES NO IF SO, WHEN? _____

CHEMCIAL PEEL? YES NO IF SO, WHEN? _____

COLLAGEN OR BOTOX? YES NO IF SO, WHEN? _____

FACIAL SURGERY? YES NO IF SO, WHEN? _____

TO HELP DETERMINE FACIAL REGIMEN, CIRCLE SKIN TYPE:

THICK | THIN | SAGGY | FIRM | SENSITIVE | RESILIENT | NORMAL | DRY

ROSACEA | ECZEMA | OILY | ACNE | PRONE TO BREATKOUTS | ACNE SCARRED

T-ZONE/COMINATION | LARGE PORES | SMALL PORES | FECKLED/SUN DAMAGED

CIRCLE SKIN TONE:

PALE/WHITE | LIGHT | MEDIUM | REDDISH | FRECKLED | OLIVE | LT. BROWN

MED. BROWN | DK. BROWN | BLACK

WHAT IMPROVEMENTS WOULD YOU LIKE TO SEE IN YOUR SKIN? _____

WHAT SKIN PRODUCTS DO YOU USE? _____

WHAT TYPE OF FACIAL TREATMENT DID YOU HAVE LAST? _____

WHAT DID YOU ENJOY MOST ABOUT YOUR LAST TREATMENT? _____

WHAT DID YOU ENJOY LEAST ABOUT YOUR LAST TREATMENT? _____

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CONSENT AGREEMENT

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the provider updated as to any changes in my medical profile and understand that there shall be no liability Daniela Hortencio should I fail to do so.

My questions regarding the treatment have been answered satisfactorily. I understand the treatment and accept any risks. I hear release (individual) and (facilitor) from all liabilities associated with the indicated treatment.

I agree that this consent supersedes any previous verbal or written disclosures. This consent is valid for all of my facial treatments in the future as well.

_____	_____	_____
Signature of Patient or Gardian	Print Name/Relationship	Date

_____	_____	_____
Signature of Witness	Print Name/Relationship	Date