Wicked
MED SPA

Facial Consent

Please answer the following questions so that I may have a better understanding of your general health and lifestyle, thereby enabling me to accurately analyze and assess your skin care needs.

Which skin conditions do you want to improve with your service today? (please check all that apply)

☐ Hyperpigmentation (Brown Spots)	☐ Age Spots	☐ Sun Damage
☐ Enlarged Pores	☐ Facial Scars	☐ Other ______________________
☐ Fine Lines & Wrinkles	☐ Age Spots Surgucal	☐

Please check if presently using any of the following? (please check all that apply)

☐ Accutane	☐ Topical Vitamin C
☐ Hydroquinone	☐ Glycolic Acid/Alpha Hydroxy Acid
☐ Retinoid (Vitamin A derivatives) Retin A, Renova, Differin	

Have you ever had an allergic reaction to any skin product or cosmetic? ____

What medications do you take on a regular basis? ____

How is your general health? Excellent Good Fair Poor

What skin care products are you currently using? ____

What is it about your skin that you would like to change? ____

Do you use a sunscreen/sun block?	☐ Yes	☐ No
Do you sunbathe or participate in outdoor activities?	☐ Yes	☐ No
Have you had skin treatments (facials) before?	☐ Yes	☐ No
Are you currently having facials?	☐ Yes	☐ No
Have you had electrolysis or waxing in the past week?	☐ Yes	☐ No

Do you take nutritrional supplements?	☐ Yes	☐ No
Do you wear contact lenses?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Are you allergic to asprin?	☐ Yes	☐ No
Are you allergic to Iodine or Seaweed?	☐ Yes	☐ No
Do you have any other allergies?	☐ Yes	☐ No
If yes, list: ___________________________________		
Are you on hormone replacement therapy?	☐ Yes	☐ No
Are you presently taking birth control pills?	☐ Yes	☐ No
Are you pregnant or planning to be?	☐ Yes	☐ No
Do you have or have ever had acne?	☐ Yes	☐ No
Are you using or have ever used any medications for acne?	☐ Yes	☐ No
Name of medication: __________________________		
Have you seen a Dermatologist in the past year?	☐ Yes	☐ No
If yes, list reason for visit ____________________		
Have you ever had Herpes(cold sores)?	☐ Yes	☐ No
Have you ever been treated with Zovirax or any medications for Herpes?	☐ Yes	☐ No
Do you have Epilepsy or Diabetes?	☐ Yes	☐ No
Are you presently under a physicians care for any reason?	☐ Yes	☐ No
Explain ____________________________________		
Do you use Biore or snore strips?	☐ Yes	☐ No
Have you had any of the following?	☐ Yes	☐ No

☐ Cosmetic Surgey	☐ Skin Cancer	☐ Laser Resurfacing
☐ Botox	☐ Dermatitis	☐ Chemical Peels
☐ Injections	☐ Keloid Scarring	☐ Hepatitis
☐ Other *(Specify)* ________________________________		

Is there any other information I should know before beginning your treatment? ____________________________________

I have read and fully understand the information filled out above. I understand the procedure and accept the risks. I do not hold the esthetician or Belfiore responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

Guest's Signature_______________________ **Print Name** ______________________________________ **Date**______________

Please be advised while visiting with us, Belfiore will not be responsible or liable for any lost/ misplaced items.

Consent to Treat a Minor: By my signature below, I hereby authorize______________________to administer skin care services to my child or dependent as the esthetician deems necessary.

Signature of Parent of Guardian____**Date**____________________________