Aesthetics by Constance
1660 South Albion Street
Tower 1660, Suite 1004
Denver CO 80222
(303) 995-1344

Client Information

-Please write legible-

Name _____Today's Date:_____

Your Address (City, State, Zip)

_____

Work/Cell (circle one)_____

Email Address _____

Date of Birth (month/date)_____

Emergency Contact _____ Phone_____

1. How did you hear about us? ___Advertisement
2. ___Family/Friend

2. Would you like to receive special promotions and offers via email? Yes/No

3. Confirm appointment by text, call, email? (Circle one)

abc
AESTHETICS BY
CONSTANCE

Medical Background

For Women Only:

Are you trying to become pregnant? (Circle one) Yes/No

Are you pregnant or lactating? (Circle one) Yes/No

Have you ever been told you have Melasma or pregnancy mask? (Circle one) Yes/No

1. Have you ever received professional skin care/aesthetic treatments? Yes / No
If yes, what type?_____

2. Have you been under the care of any physician, dermatologist, or other medical professional within the past year?
If so please explain:_____

3. List any medications, supplements, or herbal/homeopathic remedies you currently take:_____

4. Are you using any topical medication or exfoliating acids like salicylic or glycolic? (Yes / No)
If yes, explain:

_____

5. Have you ever had an adverse reaction to a product? (Yes / No) If yes, explain:

_____

6. What products are you currently using on your face?

_____

7. How would you rate the overall quality of your skin? (Circle one)
POOR FAIR GOOD VERY GOOD EXCELLENT

8. What improvements would you like to see to your skin?

_____

9. When exposed to the sun, do you: (circle one)
ALWAYS BURN USUALLY BURN SOMETIMES BURN RARELY BURN NEVER BURN

10. How much UV exposure do you get? (sun tanning, tanning beds, commuting)_____

11. How many glasses/cups of water do you drink

12. How much caffeine do you consume in a day? _____

13. Do you smoke? (Circle one) Yes/No

14. On a scale of 1-10, how would you rate your current stress level?
(LOW) 1 2 3 4 5 6 7 8 9 10 (HIGH)

15. How often do you exercise? _____

16. How many hours of sleep do you get a night? _____

17. Have you ever been treated for: (Circle all that apply)

Acne Depression Skin Disease High Blood Pressure Frequent Cold Sores
Diabetes Skin Cancer Hormone Imbalance Hepatitis Herpes Skin Lesions
Keloid Scarring Metal Bone Pins/Plates

19. Do you wear contact lenses? (Yes / No) and Are you wearing them now? (Yes / No)

20. If you wear a hormone or nicotine patch, please indicate which kind and where you wear it:
_____

21. Are you bothered by scents, oils or lotions? Have you ever had an allergic reaction (to anything) ect. food, sunscreens, or AHAs? (Yes / No)
If yes, explain:_____

22. Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid, or any Vitamin A/Retinol derivative? Yes / No If yes, have you used these products within the last 3 months? Yes / No

23. Have you ever used an acne medication? If yes, when?

ClientSelf-Assessment, WOMEN ONLY:

1. Do you have any of the following (mark in parenthesis) :

Scar ( ) Stretch Marks ( ) Hyper-pigmentation ( )

2. Do you suffer from any of the following (mark in parenthesis :

Acne ( ) Oiliness ( ) Psoriasis ( ) Blackheads( ) Dehydration( )
Vein Circulation Problems ( ) White Heads ( ) Eczema( ) other( )

Client Informed Consent to Treatment

- I have not used a scrub, Retin-a, take home microdermabrasion or glycolic peel in the last 72 hours _____initial
- I understand that with any treatment certain risks are involved and complication and/or side effects from known or unknown causes would occur, I freely assume these risks _____initial
- I have no allergies to Iodine (seaweed) _____initial
- I am not Epileptic _____initial
- I do not have heart circulation problems _____initial
- It is recommended to discontinue use of all AHA's, glycolic, Retin A, Renova or any exfoliating products for up to two days post skincare procedure. Using hydrating, soothing and antioxidants for soothing. No sun exposure or tanning beds for up to 72 hours.
- (Recommended) to use at least SPF 30 sunscreen _____initial
- I am over 18 years of age, or have parental consent co-signed below _____initial
- I will call to inform of any complications or concern I may have as soon as they occur _____initial
- I have been off Accutane for at least 6 months _____initial
- Payment has been explained to me _____initial
- Missed appointments not cancelled within 24 hours will be charged full fee _____initial
- Late appointment may need to be rescheduled or appointment modified _____initial

Skin Care Consent Form

I certify that the above information is correct to the best of my knowledge. In accordance with the law, Aesthetics/Skin Care Therapy cannot cure, treat, prevent or diagnose any condition. These treatments are used as regimens for improving skin appearance and wellness. Information exchanged during any session should be given at my own discretion.

Because certain aesthetic treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the skin care therapist updated as to any changes in my health prior to any future sessions and understand that there shall be no liability on the therapist's part nor on the part of Aesthetics by Constance and its affiliates should I fail to do so.

The therapist reserves the right to refuse service to anyone for any reason.

If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the products and/or techniques may be adjusted to my level of comfort.

By signing below I acknowledge that I have read and understand all parts of this consent/intake form, and that I have had the opportunity to ask any questions with regard to any services or therapies offered.

All client information is confidential.

Clients Name:

Printed_____

Client Signature and/ or adult signature if client is under the age of 18 _____

Date of treatment (consultation)_____