# Organic Facial Treatment

Name: ______________________________________________Date:__________________________________

Address: ______________________________________ Apt # __________City/Prov _____________Postal code _______________

Telephone: Home: ______________________ Cell: __________________________ Work: _________________________

Email: _______________________________________Can we add you to our seasonal mailing list? Yes___ No___

Do you prefer to be contacted by phone ________ email _____ or either _____

Date of birth: ____________________ Occupation: ______________________________

Physician/Dermatologist: ___________________________________Address: _______________________________________________

Referred by:

| ☐ Friend | ☐ Walk-by | ☐ Mailer | ☐ Internet search | Other: |
|---|---|---|---|---|

Are you currently receiving treatment from another health care professional? (eg. Chiropractor, Naturopath, Acupuncture, Physiotherapy, Dermatologist) ____________________________________________________________________________________________

Emergency Contact: Name:_________________________________________ Phone number: _______________________________

Medications (oral & topical): ____________________________________________________________________________________________

Supplements:__________________________________________________________________________________________

Allergies:

| ☐ Sulfur | ☐ Blueberries | ☐ Pineapple | ☐ Ragweed | Other: |
|---|---|---|---|---|
| ☐ Essential oils | ☐ Algae | ☐ Papaya | ☐ Salicylic acid | |
| ☐ Strawberries | ☐ Seaweed | ☐ Nuts | ☐ Aloe Vera | |

1. Is this your first facial? Yes ___ No ___
2. What is the reason for your visit today?
   _____________________________________________________
   _____________________________________________________
3. What special areas of concern do you have?
   _____________________________________________________
   _____________________________________________________
4. Are you presently under a physician's care for any current skin condition or other problem? Yes ___ No ___ What?____________
5. Are you pregnant? Yes ___ No ___
6. Are you taking birth control pills? Yes ___ No ___
7. Hormone Replacement? Yes ___ No ___
8. Do you wear contact lenses? Yes ___ No ___
9. Do you smoke? Yes ___ No ___
10. Do you often experience stress? Yes ___ No ___
11. Have you had skin cancer? Yes ___ No ___
12. Are you using (or used in the past): Azelex ___ Differin ___ Renova ___ Retin A ___ Tazarac ___ Glycolic or Alpha Hydroxy Acids ___
    If so, when and for how long? ___________________________________
13. Are you now using or have you ever used Accutane? Yes____ No ___
    Is so, when and for how long? __________________________________
14. Do you have acne? Yes ___ No ___
    Experience frequent blemishes? Yes ___ No___
    If so, how frequently? ________________________________________
15. Have you had botox? Yes ___ No ___
    If yes, what area(s)? _________________________________________
    Last botox treatment date _____________________________________
16. What products do you use presently?
    - ☐ Soap
    - ☐ Cleanser (Gel or Cream)
    - ☐ Toner
    - ☐ Scrub/exfoliant
    - ☐ Mask
    - ☐ Creams
    - ☐ Sunscreen

    Other: _______________________________________________

## CLIENT'S CONSENT TO TREATMENT

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the therapist to stop or alter the treatment or clarify the reason for a therapeutic technique being used.

Date: ____________________________ Signature: ___________________________________________