6919 N Dale Mabry Hwy Suite 300 Tampa, Fl. 33614
813-770-6753 | www.CrystalsSkinandBeauty.com

Name_____ Date_____

Address_____ Birthdate_____

City_____State_____Zip_____ Referred By_____

Phone_____ Cell_____

E-Mail_____

Facial Analysis

*For an effective personalized treatment, please be as accurate as possible.

1. Skin Type

__Normal __Dry __Sensitive __Combination __Oily __Breakout __Rosacea __Acne __Mature

Ethnic Skin Type

__Caucasian __Afican American __Hispanic __Asian __Indian __Other_____

2. What are your present skin concerns?

Please check all that apply

__Acne Lesions (cysts) __ Breakouts/acne __Blackeads __Whiteheads __Acne Scars__Enlarged Pores
__Hyperpigmentation (brown spots from sun, scars, hormaonal) __Sun spot/liver spot/brown spot __Uneven skin tone
__Sun damage __Rosacea __Broken capillaries ___Redness __Excessive oil/shine
__Wrinkles/fine lines ___Loss of Elasticity __Dull skin ___Dry skin ___Dehydrated
Other (please explain)_____
_____

3. How often do you receive a facial?

__Regularly __Seldom__Rarely __Never

4. Have you recently received any of the following spa services?

( )Microdermabrasion Date_____ ( )Waxing Service Date_____ ( )Enzyme/Acid Peel Date_____

5. Have you received any of the following medical or surgical procedures?

__Rhytidectomy(Face Lift) Date_____ Medical Acid Peel Date_____
__Rhinoplasty(Nose) Date_____ Collagen Injections Date_____
__Blepharoplasty(Eye Lift) Date_____ Restylane Injections Date_____
__Laser Resurfacing Date_____ Botox/Dysport Date_____

CRYSTAL'S
Skin & Beauty

General Health Record

6. Have you ever been diagnosed with any of the following skin disorders?
__Acne __Seborrhea __Eczema __Psoriasis __Skin Cancers __Rosacea
__Mycosis (fungal infection) __Contact Dermatitis __Other_____

7. Do you suffer from ANY allergies? (Cosmetic ingredients, food, shellfish, seafood, iodine, medications, hay fever, latex)
____No ___Yes (please specify_____

8. Are you currently undergoing chemotherapy or radiation?
____No ___Yes (please specify_____

9. Are you currently taking any medications?
___**Internal**_____

___**Topical**_____

Do you use retina? If yes, when is the last time you used your retina product_____

10. Have you ever been prescribed Accutane? If yes, last date used? _____

11. Have you ever been diagnosed with any of the following?

__Anxiety	__High Blood Pressure	__Cancer	__HIV
__Depression	__Low Blood Pressure	__Diabetes	__Other_____
__Migraines	__Thyroid	__Hemophilia	
__Asthma	__Epilepsy	__Hepatitis	
__Sinus Problems	__Heart Problems	__Herpes	

12. Do any of the following apply to you?
__Smoke __Eat Spicy food __Exercise __Wear Contact Lenses __Pace Maker __Metal Rods/Plates

13. When exposed to the sun, do you?
__Burn Easily __Never Burn __Tan Easily __Never Tan

14. For Woman Only…
___Regular Menstruation ___Pregnant ___Lactating ___Hormonal Problems ___Menopause
___Birth Control Pill ___IUD (Copper or plastic) ___Other_____

May I contact you via mail/email about future promotions and news? No_____ Yes_____
May I use your picture for educational and or advertising purposes? No_____ Yes_____

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Prior to receiving treatment(s), I have completed the Confidential Consultation Form accurately. I have been candid in revealing any condition that may have a bearing on this procedure, such as pregnancy, recent facial peels or surgery, laser resurfacing, allergies, tendencies to cold sores and fever blisters, use of Retin-A, Accutane, and recent or upcoming exposure to ultraviolet rays(sun or tanning beds).

I understand there may be some degree of minor discomfort, such as, itchiness, redness, and stingy. I understand that the possibility of irritation and redness exists that I should notify Crystal's Skin & Beauty if irritation persists.

I understand there are no guarantees to this procedure, and that to achieve maximum results; I may need several ongoing treatments and use a daily product over a period of time, including sunscreen.

I understand that I cannot have this procedure if I have any sunburn, or have been recently exposed to the sun preceding this procedure. I understand that I will not expose myself to ultraviolet rays (sun or tanning beds) after this treatment for at least 72 hours.

I acknowledge that I have been given post-treatment instructions and that I will follow the home care program specifically designed for me without changing or adding any products without consulting my skin care professional.

I acknowledge that the possibility of adverse reaction can occur and that this is the case regardless of the precautions taken. I accept sole responsibility for the treatment(s) I receive and for any medical care that may become necessary. I will immediately contact the Esthetician who performed the treatment of any adverse reactions. In the event that I cannot reach such person, I will immediately seek medical care.

The Esthetician has provided the information necessary for me to have made the informed decision to proceed with the treatment(s). He/She has answered all of my questions concerning the treatment(s). I clearly understand the above information.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that is supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

_____ _____

Client's Signature Date