Soleil
Wellness & Day Spa

Alexis Rose Esthetics Facial Consent Form

Name: ____ Date of Birth: ________________

Address:____ Phone:_______________________

E-mail: __________________________________

What would you like to achieve from your treatment today? ______________________________________

Your Medical History

Are you currently under the care of a physician? ◻ Yes ◻ No

Have you experienced any of these health conditions in the past or present?

◻ Hormone Imbalance ◻ Cancer/Systemic Disease ◻ High Blood Pressure ◻ Arthritis
◻ Heart Problem ◻ Auto-Immune Disorder ◻ Asthma ◻ Diabetes
◻ Epilepsy/Seizures ◻ Headaches/ Migraines ◻ Cold Sores ◻ HIV/AIDS
◻ Lupus

Any Known Allergies

◻ Aspirin ◻ ShellFish ◻ Tree Nuts ◻ Pollen
◻ Latex ◻ Lidocaine ◻ Dairy ◻ Fruits
◻ Fragrance/ Essential Oils ◻ NONE Explain: ____________________________

List any medications/supplements you are taking: ____

Have you ever received botox or fillers? ◻ Yes ◻ No If yes, when and where? _________________________

Have you ever experienced claustrophobia? ◻ Yes ◻ No

Your Skin Care

Have you ever had a facial treatment before? ◻ Yes ◻ No If yes, when? __________________________

Which of the following best describes your skin type? (Please circle one type number)

I: Creamy complexion, always burns easily, never tans

II: Light Complexion, always burns, tans slightly

III: Light/Matte Complexion, burns moderately, tans gradually

IV: Matte Complexion, seldom burns, always tans well

V: Brown Complexion, rarely burns, deep tan

VI: Black Complexion, never burns, deeply pigmented

What are your skin concerns?

◻ Breakouts/Acne ◻ Blackheads/Whiteheads ◻ Excessive Oil/Shine ◻ Rosacea
◻ Hyperpigmentation ◻ Redness ◻ Broken Capillaries (Enlarged Blood Vessels)

Explain: ____

What would you say your skin type is?
□ Normal (no visible blemishes, fine pores, smooth texture)
□ Combination (oily and dry patches, oily t-zone, hormonal breakouts)
□ Acne (cystic or nodules)
□ Sensitive (reactive to fragrance, often irritated)
□ Oily (enlarged pores,
□ Dry (dull, visible lines and wrinkles, feels tight)

What skincare products do you use on a daily basis?

□ Soap
□ Toner
□ Mask
□ Eye Cream
□ Day Cream (Moisturizer)
□ Night Cream (Moisturizer)
□ SPF
□ Cleanser
□ Exfoliant (Physical or Chemical)
□ Serum
□ Vitamin A (Retinol)

Do you experience routine breakouts or acne? □ Yes □ No
Have you been diagnosed with eczema, psoriasis or rosacea? □ Yes □ No
Have you received waxing/ sugaring, threading, or laser/electrolysis in the last 7 days? □ Yes □ No
Do you currently use accutane, retin-A, prescribed topical cream or any acne medication? □ Yes □ No
Please specify what product or type, if you answered YES to the question above ______________________________

Are you currently using products that contain:

□ AHA (glycolic acid, lactic acid, etc.)
□ BHA (salicylic acid)
□ Exfoliating scrubs
□ NONE
□ Vitamin A derivative (retinol/retinoids)
□ Retin-A, Renova, Adapalene Hydroxy Acid, or Retinol/Vitamin A Derivative Products

Have you ever received chemical peels, laser services, or microdermabrasion treatments? □ Yes □ No
If yes, when? ____

Do you?

□ Wear contact lenses
□ Have metal implants
□ Frequent tanning beds
□ Consume Caffeine
□ Have a pacemaker
□ NONE

Female Clients Only:
Are you taking oral contraceptives? □ Yes □ No Specify:______________________________
Are you pregnant or trying to become pregnant? □ Yes □ No
Are you lactating? □ Yes □ No
Any menopause problems? □ Yes □ No Specify:______________________________
Are you undergoing any hormone replacement therapy? □ Yes □ No Specify:______________________________

Future Appointments/Contact:
Preferred appointment confirmation: ____ Text ____ Email ____ Phone call

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it 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 the practitioner and/or Soleil Wellness & Day Spa from liability and assume full responsibility thereof.

Client Signature: ______________________________________ Date:__________________