BORA LEA
SKIN THERAPY

ESTHETICS CLIENT RECORD

You are asked to provide this information to ensure the best possible outcome from your skincare treatment. This information is confidential and will not be shared with any third parties. Thank you for taking the time to complete this form its entirety.

Name: ______________________________ **Today's Date:** ______________

Address: ______________________________ **City:** ______________ **zip:** __________

e-mail: ______________________________ **Birthdate:** ______________

Day Phone/Cell: ______________________________ **May we text appointment reminders to this number?** ______

Do you consent to appear in pictures that may be used in our social media? YES/ NO May we tag you ?@ ______________

How did you hear about me? Yelp Google Instagram Facebook Referred by: ______________

What effects / improvements would you like to see on your skin?

CLIENT HEALTH HISTORY - PLEASE CHECK OR FILL IN THE BLANKS

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□ □ **Are you using or recently used any medication or products (internally or topically) that may cause you to bruise, bleed or make your skin more sensitive, such as antibiotics, Retinoids, Accutane, acne creams, AHAs, blood pressure medication, blood thinners, aspirin/ibuprofen, fish oil, etc… Please circle or list**

□ □ **Do you take vitamins/supplements frequently?**

□ □ **Do you have any allergies? (foods / animals / pollens / medications etc.…) Please list**

□ □ **Have you undergone facial or neck surgery in the last 12 months & should we avoid the area during treatment?**

□ □ **Do you have a pacemaker or any metal implants in your face/jaw/skull that may be affected by electrical current in facial devices?**

□ □ **Do you smoke?**
□ □ **Have you had chemical peel(s)?**
□ □ **Do you blush/flush easily?**
□ □ **Have you experienced claustrophobia?**
□ □ **Do you have chromic sinus problems?**
□ □ **Do you wear contact lenses?**
□ □ **Do you engage in athletic activity/sports often?**
□ □ **Do you wear SPF most days / sometimes / rarely**

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□ □ **Do you follow a special diet/eating plan (examples: Atkins, Low Sodium, Vegan, Gluten-Free, Low Calorie, etc…)**

Daily intake of caffeinated beverages: _____**cups.**

Daily water intake: __________**cups**

Rate your stress level on a scale from 1 to 4 (1= lowest): __________

□ □ **Have you ever had an adverse reaction to a cosmetic product? Please specify the product or ingredient:**

□ □ **Have you ever had a facial before?**
Was there anything you especially liked or disliked about the treatment?

What type of massage do you prefer? Light Heavy

What are you currently using to cleanse your face?

What (if any) are you currently using to moisturize?

Do you use any special treatments? (eye cream, night cream, serum, mask, peel kit, etc…)

Female Clients:

□ □ **Are you using a hormonal contraceptive**
□ □ **Are you pregnant?**
Menopausal___?/Post Menopausal___?

Male Clients:

□ □ **Do you experience irritation from shaving**
□ □ **Do you experience ingrown hairs?**
Current saving system: Wet___/Electric___

Client Signature______________________________

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