BORA LEA
SKIN THERAPY

ESTHETICS CLIENT RECORD

This information is confidential and will not be shared with any third parties. You are asked to provide this information in order to ensure the best possible skincare treatment, as well as ensuring your safety and that of your esthetician.
Thank you in advance for your cooperation.

Name: _____ **Today's Date:** _____

Address: _____ **City:** _____ **zip:** _____

e-mail: _____ **Date of Birth:** _____ **Age** _____

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

How did you hear about me? Friend, Yelp, Google Search, Facebook, On-Line Voucher, Other:

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

CLIENT HEALTH HISTORY - PLEASE CHECK OR FILL IN THE BLANKS

Y	N	
□	□	Are you currently under a physician's care?
□	□	Circulation problems?
□	□	Liquid retention?
□	□	Are you using any prescription medication (internally or topically on your skin) ? These often have an effect on the skin. Kindly list them even if you are unsure of their relevance.
□	□	Have you ever used Accutane?
□	□	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 year?
□	□	Do you have any metal implants? (Pacemaker, pins in bones, etc..)
□	□	Have you tested positive for: HIV or Hepatitis B
□	□	Do you smoke?
□	□	Have you had chemical peel(s)?
□	□	Do you blush easily?
□	□	Have you experienced claustrophobia?
□	□	Do you have sinus problems?
□	□	Do you wear contact lenses?
□	□	Do you engage in athletic activity/sports often?
□	□	Do you wear sun screen most days

Y	N	
□	□	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): _____

Y	N	
□	□	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___