



NAME _____ DATE _____

PHONE _____

ADDRESS _____

EMAIL _____

SPOUSE'S NAME _____ SPOUSE'S CELL _____

HOW DID YOU HEAR ABOUT US? _____

DO YOU HAVE? (CIRCLE ALL THAT APPLY) DIABETES HIGH BLOOD PRESSURE

KELOIDS (RAISED SCARS) EPILEPSY METAL IMPLANTS SKIN DISORDER

PLEASE LIST ANY OTHER HEALTH CONCERNS? _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY KIND OF CANCER? _____ IF YES, PLEASE
TELL YOUR PROVIDER NOW, SO THEY CAN DETERMINE IF ANY MODIFICATIONS NEED TO
BE MADE AND GET YOU A CAT FORM.

PLEASE LIST ANY SKIN ISSUES _____

HAVE YOU EVER HAD A COLD SORE? _____ LAST OCCURRENCE _____

PLEASE LIST ANY AND ALL ALLERGIES _____

DO YOU WEAR CONTACTS? _____ WEARING THEM NOW? _____

DO YOU DRINK AT LEAST 64 OZS OF WATER A DAY? _____

PLEASE RATE YOUR STRESS LEVEL ON A SCALE OF 1 TO 5 (1 BEING THE LOWEST) _____

PLEASE RATE YOUR PAIN TOLERANCE ON A SCALE OF 1 TO 5 (1 BEING THE LOWEST) _____

IN YOUR SPA TREATMENTS, DO YOU PREFER: TOTAL SILENCE _____ FRIENDLY CHATTER _____

MIXTURE OF SILENCE AND CHATTER _____

HAVE YOU EVER EXPERIENCED CLAUSTROPHOBIA? YES NO

ARE YOU PREGNANT OR TRYING TO BECOME PREGNANT? YES NO
ARE YOU ON YOUR MENSTRUAL CYCLE? YES NO
DO YOU EXPERIENCE INGROWN HAIRS? YES NO
HAVE YOU EVER BEEN ON ACCUTANE? YES NO WHEN? _____
WHAT SKIN CARE PRODUCTS DO YOU CURRENTLY USE FOR HOME CARE? _____

WHAT PRESCRIPTION SKIN CARE PRODUCTS DO YOU USE, IF ANY? _____

DO YOU HAVE PERMANENT MAKEUP? _____ AREAS? _____

ARE YOU SENSITIVE TO THE SUN? _____

DO YOU HAVE EYELASH EXTENSIONS? _____

DO YOU WAX? _____ WHAT AREAS? _____

DO YOU GET BOTOX OR FILLERS? _____ WHEN? _____

WHAT AREAS? _____

HAVE YOU HAD ANY LASER TREATMENTS IN THE LAST 6 MONTHS? YES NO

PLEASE CIRCLE ANY SERVICES YOU ARE INTERESTED IN NOW OR POSSIBLY IN THE FUTURE:

FACIALS DERMAPLANING MICRODERMABRASION CHEMICAL PEELS

WAXING LED THERAPY EYELASH EXTENSIONS LASH LIFT

REMOVAL OF SKIN TAGS, ANGIOMAS, BROKEN CAPILLARIES, SUN SPOTS, FIBROMAS, KERATOSIS, CHOLESTEROL DEPOSITS, MILIA, SEBACEOUS HYPERPLASIA

I AFFIRM THAT THE ANSWERS I HAVE PROVIDED ARE CORRECT AND THAT I HAVE NOT WITHHELD ANY INFORMATION THAT MAY BE RELEVANT TO MY TREATMENT. I RELEASE TRANQUIL OASIS AND JAYMIE MARTINEZ FROM ANY LIABILITY AND ASSUME FULL RESPONSIBILITY FROM THE SERVICES I VOLUNTARILY RECEIVE. I HAVE REVIEWED MY CONSULTATION AND THAT IS EVIDENT BY MY SIGNATURE BELOW.

CLIENT SIGNATURE _____ DATE _____

ESTHETICIAN SIGNATURE _____