# EPIPHANY
## SPA & BOUTIQUE

# Consultation Card/ Face Mapping

Name: ___________________________

Birthday _____ / _____ Aesthetician _______________
day month please leave blank

❏ <21 ❏ 21-30 ❏ 31-40 ❏ 41-50 ❏ 51-60 ❏ 60+

Street Address: ___________________________ *How did you come to hear of us?*

City: ___________ Province: _______ Postal Code: ___________ ___________________

Cell phone: ___________________ other phone: ___________________

Email: ___________________________________________
p l e a s e p r i n t c l e a r l y

❏ Check this box to give us your consent to receive valuable VIP emails. Your email address is kept confidential. Hassle-free cancel anytime.

Emergency contact: ___________________________
Name and phone number

**Your Health:** *(Please circle the answer that most applies)*

*Within the past year, have you been under the care of a dermatologist or other physician* Yes No
*Within the last nine months, have undergone any surgery?* Yes No
*If yes, please specify* ___________________________

**Do you:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| *Smoke?* | Yes | No | *Excercise regularly?* | Yes | No | *Wear contact lenses?* | Yes | No |
| *Have metal implants?* | Yes | No | *Have a pacemaker?* | Yes | No | *Have body piercings?* | Yes | No |
| *Do have allergies?* | Yes | No | *If yes, what allergies do you have?* ___________ | | | | | |

**Your skin:**

*Do you have any skin problems relating to your face or body?* Yes No
*If yes, please specify* ___________________________
*What skincare products do you use regularly?*

Face: ❏ soap ❏ cleanser ❏ toner ❏ moisturizer ❏ masque ❏ exfoliator ❏ eye products

Body: ❏ soap ❏ shower gel ❏ scrubs ❏ oil ❏ body moisturizer ❏ depilatory products ❏ self tanners

**Exfoliation History:**

| | | | | | |
|---|---|---|---|---|---|
| *Have you ever had a chemical peel?* | Yes | No | *In the last 30 days?* | Yes | No |
| *Have you ever had a microdermabrasion treatment?* | Yes | No | *In the last 30 days?* | Yes | No |
| *Have you ever had a resurfacing treatment?* | Yes | No | *In the last 30 days?* | Yes | No |
| *Do you use Accutane, Retin A, Renova, Adapalene or any other prescription skin products?* | | | | Yes | No |
| | | | *In the last 90 days?* | Yes | No |

*Are you currently using any products that contain the following ingredients?*

❏ glycolic acid ❏ lactic acid ❏ any exfoliating scrubs ❏ any hydroxy acid product ❏ vitamin A derivatives (i.e. retinol)

**Oil Secretion:**

*Do you ever experience oily shine during the day?* Yes No ❏ Occasionally
*Do you ever experience skin breakouts?* Yes No ❏ Occasionally

**Moisture Hydration:**

*How much plain water do you consume on a daily basis?* ______________________________

*Do you ever experience the following conditions on your skin?* ❏ flakiness ❏ tightness ❏ obvious dryness

*What SPF sunscreen do you use on your face?* ____________ On your body? ____________

*Do you sunbathe (or use tanning beds)* Yes No

**Capillary Activity:**

*Do you burn easily in moderate sunlight?* Yes No *Do you blush easily when nervous?* Yes No

*Do you have a tendancy to redness?* Yes No *Do you suffer from sinus problems?* Yes No

**Nerve Activity:**

*Do you drink more than 4 caffeinated bereverages daily? (coffee, tea, soft drinks)* Yes No

*Do you experience a burning, itching sensation on your skin?* Yes No

*What is your pain threshold?* Low Medium High

*Have you ever experienced claustrophobia?* Yes No

*What type of massage pressure do you prefer?* Light Medium Firm

*Have you ever had a reaction to any of the following?* ❏ cosmetics ❏ medicine ❏ iodine ❏ pollen ❏ food ❏ animals ❏ hydroxy acids ❏ fragrances ❏ sunscreens ❏ other ______________________________

**Female Clients Only:**

*Are you taking oral contraception?* Yes No *Are you pregnant or trying to become pregnant?* Yes No

*Are you lactating?* Yes No

**Maile Clients Only:**

*What is your current shaving system?* ❏ electric ❏ wet shave

*Do you experience irratation from shaving?* Yes No *Do you experience ingrown hairs?* Yes No

**Feel free to ask any questions related to your skin care and please discuss the following at every visit:**

*Are you currently having or due for your menstrual period?* Yes No

*Have you started any new medication since your last visit?* Yes No If yes, what? ____________

*What are your skin care goals?*______________________________

So, why so many questions? We have extensive experience as aestheticians and the more we know about you and your skin care needs, the more we can help you reach your skin care goals? This consultation card helps to evaluate your skin care needs. This information is confidential and may be disclosed only to staff members, risk or quality assurance personnel and only to assess the quality of care gven and will not be shared with a third party for any reason.

I confirm, to the best of my knowledge, that the answers I have provided are correct and that I have not withheld any information that may be relevant to my treatment.

| ____________ | ____________ | ____________ | ____________ |
|---|---|---|---|
| Client signature | today's date | Aesthetician's signature | today's date |