Facial Treatment Record Card

STRICTLY PROFESSIONAL

Name _____ Date of Birth _____ Tel: (Home) _____

Address _____ Tel: (Work) _____

_____ Mobile: _____

Dr Name _____ Practice _____ Tel: _____ Email: _____

Present Medical Treatment _____ Medication/Supplements _____

_____

Allergies _____ Liquids Consumed _____

Client Main Concerns and Expectations _____ Previous Facial Treatments _____

_____ _____

General Questions

☐ Diabetes	☐ Circulatory Conditions	☐ High or Low Blood Press	☐ Asthma	☐ Hay Fever
☐ HRT	☐ Back or Joint Problems	☐ Headaches/Migraine	☐ Psorasis	☐ Eczema
☐ Epilepsy	☐ Type of Diet	☐ Botox/Fillers	☐ Contact Lenses	☐ Recent Dental Work
☐ Smoke	☐ Waxing on the Face	☐ Laser/IPL Treatments	☐ Pregnant	

Skin Analysis ☐ **Dry** ☐ **Oily** ☐ **Normal** ☐ **Combination** ☐ **Acne** ☐ **Mature**

☐ Capillaries	☐ Scars	☐ Pustules	☐ Sun Damage
☐ Comedones	☐ Freckles	☐ Moles	☐ Dehydration
☐ Milia	☐ Shine	☐ Skin Tags	☐ Wrinkles

Indemnity/Consent

☐ I confirm that I understand the treatment and the answers I have given are true and correct.

☐ I give my consent for the treatment to take place.

Client Signature _____ Date _____ Client Signature _____ Date _____

Client Signature _____ Date _____ Client Signature _____ Date _____

Information is confidential and is only used by staff for your treatments. Details will not be passed to a third party.

Therapist Signature _____ Date of Consultation _____

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Products used at home					
☐ Cleanser	☐ am	☐ pm	☐ Toner	☐ am	☐ pm
☐ Moisturiser	☐ am	☐ pm	☐ SPF	☐ am	
☐ Other					

Date	Treatment	Details	Homecare Advice	Retail	Therapist Name