HOLISTIC MASSAGE

Consent for Facial Treatment

Client Name: _____

The goal of a Facial treatment as in any cosmetic procedure, is improvement, not perfection. I understand that my results may not be perfect. In the case of a facial treatment, the number of treatments necessary will vary among individuals and the areas being treated.
I understand that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the excepted results.

Is this your first facial treatment? Yes No
Is there any specific area(s) that concern you? _____
Are you presently under a physician's care for any skin condition or other problem? _____
Are you pregnant or think you may be pregnant? Yes No
Are you taking birth control? Yes No If yes, what type? _____
Are you taking hormone replacement medication? Yes No If yes, what type? _____
Do you wear contact lenses? Yes No
Do you often experience stress? Yes No
Have you been diagnosed with skin cancer? Yes No
Are you currently using or have you used in the past any of the listed medications? Circle all that apply.
Azelex Differin Renova Retin-A Tazarac Glycolic or Alphahydroxy Acids
How long did you use the medication circled above? _____
Do you have any allergies? Yes No If yes, what type? _____
Are you currently taking any medications? Yes No If yes, what type and for how long? _____
_____
Have you ever used Accutane? Yes No If yes, for how long? _____
Do you have acne? Yes No If yes, for how long? _____
Do you experience frequent blemishes? Yes No If yes, for how long? _____ Which of these products are you currently using on your face? Circle all that apply.
Soap Cleansing Milk Toner Scrub Mask Cream Sunscreen Other _____
How much plain water do you consume daily? _____ Have you ever experienced any of the following conditions with your skin? Circle all that apply.
Flakiness Tightness Obvious Dryness
Do you ever experience oily shine during the day? Yes No Occasionally
Are you currently having or will soon have your menstrual period? Yes No
Have you started any new medication? Yes No If yes, what type? _____ Is all the information on your health history form up to date? Yes No If no, please complete a new Health History Form.

I understand that I may have some discomfort, redness and swelling for 2 hours to 7 days, itching or irritation, skin peeling or flaking for up to 7 days after the procedure and I could have possible scarring as a result.

It is my decision to have this treatment and I certify that I have read and have full understanding of the above consent. I have been given ample opportunity for discussion and all of my questions have been answered to my satisfaction. I hereby consent to the facial treatment procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. Holistic Massage and their service providers are not responsible for any injury or allergic reaction(s) or any skin abrasions as a result of the services performed on me.

Client Signature:_____ Date_____
Aesthetician Signature:_____ Date:_____