Di Di's ESTHETICS

FACIAL TREATMENT

Consultation Form

Client Information:

Name:_____ Date of birth:_____

Address:_____

City: _____ State: _____ Zip Code:_____

Phone:_____ Email: _____

Occupation:_____

Emergency Contact Name:_____ Phone:_____

How did you hear about us?_____

Would you like to be added to our email list for specials and discounts? ◯ **Yes** ◯ **No**

Medical History:

Have you been treated for: (please circle)
Acne Skin Disease Cancer Diabetes

Any other conditions:

Are you currently under the treatment of Accutane? ◯Yes ◯No: _____

Do you smoke? ◯Yes ◯No _____

List any medications you take regularly including vitamins, herbal supplements, aspirin:

_____

Any recent surgery, including plastic surgery? ◯ Yes ◯No:_____

Are you pregnant or trying to become pregnant? ◯Yes ◯No: _____

Have you ever had an allergic reaction to any of the following (check all that apply)

Cosmetics◯ AHAs◯ Fragrance◯ Animal Dander◯
Medication◯ Food◯ Shellfish◯ Latex◯ Sunscreens◯
Aspirin◯ Other◯

If yes, please specify _____

Facial Consultation Form

(Page 2)

Skin Care History:

Please check current products you use.

- Eye Make-Up Remover
- Cleansing Cream
- Facial Soap
- Skin Toner/Astringent
- Body Soap
- Eye Cream
- Day Cream
- Night Cream
- Neck lotion
- Hand Cream
- Mask
- Facial Scrub
- Daily Sunscreen
- Body Lotion
- Body Scrub

Skin History:

What is your skin type?	Normal	Oily	Dry	Combo
Your exposure to the sun?	Never	Light	Moderate	Excessive
Are you prone to cold sores?	Yes	No		
How does your skin heal?	Fast	Slow	Scars	Pigment
Do you get brusises easily	Yes	No		

Have you ever had a facial treatment before? ◯ Yes ◯No

If yes, when was the last facial treatment? _____

What would you like to achieve from your treatment today?_____

_____

Have you in the last 72 hours used Retin-A, Renova, AHA's or Retinol/Vitamin A derivative products?

◯ No ◯ Yes

Have you had cosmetic injectables with the last 2 weeks? ◯No ◯Yes

Skin Concerns:

- Acne
- Blackheads
- Broken Capillaries
- Comedones
- Cherry Angioma
- Discoloration
- Dryness/Dull Skin
- Eczema
- Fine lines/Wrinkles
- Hyperpigmentation
- Hypopigmentation
- Keloids
- Milia
- Oily Skin
- Psoriasis
- Redness
- Rosacea
- Scarring
- Sensitivity
- Sun damage
- Thin
- Unwanted hair
- Other _____

What Skincare line are you currently using? _____

Circle how you feel about the overall quality of your skin:

(bad) 1 2 3 4 5 6 7 8 9 10 (Fantastic)

Consent

By signing below, you agree to the following:

I understand that DiDi's Esthetics values your business and ask that you respect our cancellation policy.

First time clients are required to have a credit card on file in order to book an appointment.

Should you need to cancel or reschedule, please notify us at least 24 hours prior your appointment.

Any cancelations made less than 24 hours, or if you miss your appointment will invoke a cancellation fee.

This fee will be equal to the full amount of the booked services. And will be chaged to the credit card on file.

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward DiDi's Esthetics Skincare & Massage therapists for any injury or damages incurred due to any misrepresentation of my health history.

I am stating that precautions of this treatment or any others have been explained to me in detail and I fully understand.

Client Signature: _____ Client Printed: _____ Date: _____

Esthetician Signature: _____ Esthetician Printed: _____ Date: _____

Massage Intake Form

Name _____ Phone _____
Address _____ City/State/Zip _____
DOB _____ Occupation/Employer _____
Email _____
Emergency Contact _____ Relationship _____
Phone _____
How did you hear about us? _____

Medical Information

Are you taking any medications? ☐ yes ☐ no
If yes, please list name and use:
_____
_____
Are you currently pregnant? ☐ yes ☐ no
If yes, how far along?
_____
Any high risk factors?
_____
Do you suffer from chronic pain? ☐ yes ☐ no
If yes, please explain:
_____
What makes it better?
_____
_____
What makes it worse?
_____
_____

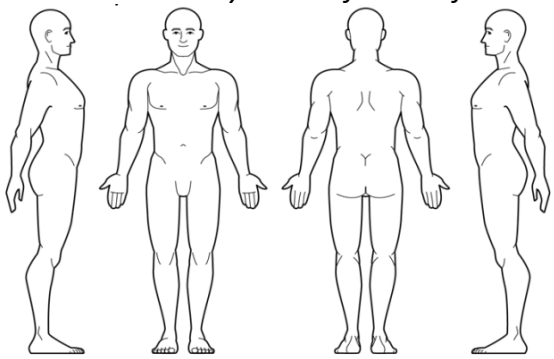
Have you had any orthopedic injuries?
☐ yes ☐ no
If yes, please list:
_____
Please indicate any of the following that apply to you: ☐ Cancer ☐ Headaches/Migraines
☐ Arthritis ☐ Diabetes ☐ Joint Replacement(s)
☐ High/Low Blood Pressure ☐ Neuropathy
☐ Fibromyalgia ☐ Stroke ☐ Heart Attack
☐ Kidney Dysfunction ☐ Blood Clots
☐ Numbness ☐Sprains or Strains

Explain any conditions you have marked above:

Massage Information

Have you had a professional massage before?
☐ yes ☐ no
What type of massage are you seeking?
☐ Relaxation ☐ Therapeutic/Deep Tissue Other
_____
What pressure do you prefer?
☐ Light ☐ Medium ☐ Deep
Do you have any allergies or sensitivities?
☐ yes ☐ no
Please explain:
_____
Are there any areas (feet, face, abdomen, etc.) you **do not** want massaged? ☐ yes ☐ no
Please explain: _____
What are your goals for this treatment session?
_____

Please circle any areas of discomfort:



By signing below, you agree to the following. I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____
Date _____
Therapist Signature _____
Date _____