LA PIELE SPA
Confidential Patient Profile

Date ____
Name _____ DOB _____ Age ____ Sex _____
Address _____
City _____ State _____ Zip _____ Phone _____
E-Mail _____ how do you hear about LA PIELE? _____
Are you pregnant or nursing? _____
Are you allergic to LATEX? ___apples____citrus____,grapes,___, aspirin,_____,
hydroquinone_____,mushrooms_____,nuts_____,strawberries____
If any other allergies, what ? _____

Please list any health conditions you have or have had _____
List oral medications including birth control_____
List topical medication if applies _____
Have you ever been treated for a skin condition? _____
If yes, please list condition treated & treatment _____
Do you use sunscreen & how frequently? _____
Any history or currently have __eczema __dermatitis __psoriasis __keloid scarring __
Do you get cold sores or fever blisters on lips or face? _____
Do you burn or tan due to sun exposure? _____ Wear sunscreen? Please list: _____
Within the last 6 weeks, please check if you have applied the following to your skin or taken orally:
__Retin-A(retinol) __Glycolic/Salicylic Acid __ Skin Lightener __Benzoyl Peroxide __Accutane __Antibiotic
__Differen, or any other prescription topical medication: Please List: _____

Have you undergone cosmetic surgery? Botox? Restylane? Please list which & when:
_____
Are you a smoker?____What is your alcohol consumption? ___ Glasses of water/ day? _____
Do you participate in vigorous activity or sports? exercise? _____ *certain peels require no activity for 2 days
What is your stress level? ____ Do you consume spicy foods? __Do you go to tanning beds or sunbathe regularly?
Are you prone to hyper pigmentation? ___ Keloid scarring _____ Anemia __
Please check Y (yes) or N (no): __High Blood Pressure __Cancer __Diabetes __Hemophilia __Lupus __Hepatitis
__Hormonal Imbalances __IBS (irritable bowel) __Constipation __ Acid Reflux
What specific areas do you want to treat? Face ___ Chest ___ Hands ____ Other: _____
What type of cleanser do you use? Soap / Gel/ Milky Does your skin feel TIGHT after you cleanse? ____
Please list all other products used daily:
_____

Please circle, which you feel, describes your skin:

Oily Tight/Dehydrated Combination Dry/Flaky Acne/Blemished Blackheads Whiteheads
Broken Capillaries Ruddy & Red Sun-damaged Uneven Tone Dull/Devitalized, Lackluster
Rough Texture Scarring Large Pores Sensitive Highly Allergic

Would you like to start a regular facial program? _____ would you like product recommendations? _____
What is your goal of TODAY'S treatment?_____ Have you ever had a facial? _____
Please list the changes you would like to see in your skin _____

We offer SPRAY TAN, CHEMICAL PEELS, MICRODERMABRASION, FACIALS, WAXING,
MAKEUP ARTISTRY, BROW SHAPING, HOT TOWEL FOOT REATMENT,
ANTI-AGING HAND TREATMENTS, BODY PEELS, BACK FACIALS, MAKEUP LESSONS
*Please circle the services you are interested in

would you like to receive promotions & discounts? _____ via email or mail? _____
FIND US ON FACEBOOK REFER A FRIEND AND RECEIVE $10 VOUCHER towards a service

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and/or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he/she deems to have a condition for which facial treatments are contraindicated. I am aware that esthetic services are cosmetic & elective, and take full responsibility if I agree to have a service. I understand that cosmetic services is not a replacement for cosmetic surgery, and multiple treatments may be necessary to achieve the desired effect. I agree to follow the esthetician's pre & post protocol for more advanced skin care treatments, and do acknowledge that if I fail to do so, complications may occur, and results may not be optimal.

Client's Name (please print) _____

Client Signature _____

Date _____ NAME:_____

ESTHETICIAN'S NAME: _____

WITNESS: _____