CONFIDENTIAL CONSULTATION FORM

First Name: _____Last Name:_____ DOB:_____
Address:_____
Phone: (H):_____ (W):_____ (C):_____
Email:_____ Referred By:_____
Primary Care Physician:_____Phone:_____
Dermatologist:_____ Phone:_____
Emergency Contact:_____Phone:_____

What is your hereditary background?

□ Nordic □ Scandinavian □ Irish □ English □ Middle Eastern
□ Asian □ Mediterranean □ Hispanic □ South Asian □ Native American
□ African American □ Other: _____

Natural Eye Color: _____ Natural Hair Color:_____
Do you consider your skin: □ sensitive □ resilient □ unsure
Check all that describe your skin:

□ Normal	□ Dry	□ Oily	□ T-Zone	□ Combination	□ Thick
□ Thin	□Saggy	□ Firm	□ Acne	□ Whiteheads	□ Blackheads
□ Milia	□ Cysts	□ Breakouts	□Large Pores	□ Small Pores	□Rosacea
□ Eczema	□ Freckled	□Melasma	□Uneven	□ Blotchy	□ Matured
□Wrinkled	□ Dehydrated	□ Sallow	□Psoriasis	□ Acne-Scarred	□ Lacking
□Age Spots	□Sun-Damaged		□Broken Surface Capillaries		Moisture

□ Other:_____
What changes would you most like to see in your skin:_____
_____
_____
What special areas of concern do you have? Check all that apply.

□ Acne Management	□ Excess Oil	□ Rejuvination
□ Age Spots	□ Fine Lines/Wrinkles	□ Scarring
□ Hair Removal	□ Pigmentation	□ Sun Damage
□ Dryness	□ Body Tightening/Firming	□ Texture
□ Bodily Inch Loss	□ Body Detoxification	□ Cellulite Appearance
□ Lash Enhancement	□ Lash/Brow Dye	

Does your job require that you work outdoors? □ Yes □ No
On average how many hours a day do you spend outdoors? _____
Have you used a tanning booth within the last 30 days? When was the last visit?_____
(You should discontinue tanning due to the damage it causes to your skin and the increased risk of cancer associated with this practice)
Have you had any type of facial treatment prior to today's visit? □ Yes □ No
If yes, please check all prior facial treatments you have received:

□ Chemical Peel	□ Injections/Fillers	□ Microcurrent
□ Cosmetic Surgery	□ Laser Hair Removal	□ Microdermabrasion
□ Dermabrasion	□ Laser Skin Resurfacing	□ Microneedling
□ Dermaplaning	□ Lash/Brow Extension	□ Permanent Makeup/Tattoo
□ Electrolysis	□ Lash/Brow Tinting	□ Sugaring
□ Facial	□ Massage	□ Waxing

Any of these services in the last 6 months? □ Yes □ No
If yes, which and when:_____

Have you used Tretinoin, Retin-A, Renova, Differin, Tazorac, Avage, EpiDuo, Ziana, Adapalene Hydroxyl, or any products containing Retinol or a Vitamin-A derivative (common identified as an "anti-aging" skin product) in the last 30 days? □ Yes □ No
If yes, which product(s) and when did you last use each?
_____
_____
Do you wear contacts? □ Yes □ No Are you wearing contacts today? □ Yes □No
Do you now or have you ever suffered from any of the following:

□ Acne	□ Eczema	□ Keloids	□ Shingles
□ Infections/Boils	□ Epilepsy	□ Keratosis	□ Skin Cancer
□ Conjunctivitis	□ Fever Blisters	□ Psoriasis	□ Varicose Veins
□ Cysts	□ Herpes	□ Rosacea	□ Warts
□ Dermatitis	□ Hyperpigmentation	□ Sebaceous Hyperplasia	
□ Diabetes	□ Ingrown Hairs	□ Spider Veins	□ Staph/MRSA

Do you presently have any type of rash, skin irritation, lesions or open wounds? □ Yes □ No
Do you have any type of communicable disease? □ Yes □ No
Do you develop cold sores or fever blisters? □ Yes □ No Last breakout? _____
Have you ever undergone Accutane therapy (isotretinoin)? □ Yes □ No
If yes, dates of therapy: _____
Please list your current medications (include all vitamins/supplements/hormones/topicals):
_____
_____
_____
Are you taking oral contraceptives? □ Yes □ No
Recent changes in oral contraceptive type? □ Yes □ No
Are you currently pregnant or do you think you might be pregnant? □ Yes □ No
Are you having your period now? □ Yes □ No
Are you lactating? □ Yes □ No
Are you presently undergoing any form of hormone replacement therapy? □ Yes □ No
Do you have or have you ever had an allergic reaction to any of the following:

□ Apples	□ Aspirin	□ Bee Stings	□ AHAs
□ Honey	□ Latex	□ Milk	□ Cosmetics
□Fragrance	□Shellfish	□ Iodine	□ Medicines

Please list any allergies you have:_____
_____
Do you have allergies to foods or ingredients? □ Yes □ No If so, please list:_____
_____
_____
Have you had any tattoos or body piercings in the past month? □ Yes □ No
Do you have any circulatory or respiratory problems? □ Yes □ No
Have you smoked or used tobacco products in the last 6 months? □ Yes □ No
Describe your facial cleansing and maintenance routines (including products used):_____
_____
Please list any other concerns you have about your skin:_____
_____
_____
Do you have any other health conditions that we should know about?_____
_____

Have you ever been treated for or diagnosed with excoriation disorder, bulimia nervosa, anorexia nervosa, obsessive-compulsive disorder, or facial/body dysmorphic disorder or dysmorphophobia or do you believe you suffer from any of these? □ Yes □ No
Have you ever used any facial, skin, or hair products that caused a bad reaction? □Yes □ No
If so, explain:_____

Would you like to receive emails and/or texts to confirm future appointments and notify you of salon specials? □ Yes □ No

I understand, have read and completed this questionnaire completely and truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing incorrect information may result in contraindications, irritation, and/or damage to the skin from treatments received. I understand if receiving a body wrap that I am being wrapped at my own risk. The treatments I receive here are completely voluntary and assume full responsibility for any treatment provided to me. I release Skinology, LLC and/or the skin care professional from all liability of any kind. Skinology, LLC reserves the right not to provide any service to any person for any reason.

Date: _____ Signature:_____

Reviewed by Esthetician on _____
Notes: _____
_____
_____
_____

_____
Esthetician Signature

Salon Policies

Unanticipated events happen occasionally in everyone's life. In the desire to be effective and fair to all clients, policies have been established concerning cancellations and late arrivals. If you would like to schedule a same-day appointment, all reasonable efforts will be undertaken to accommodate your needs. Out of respect to all, please adhere to these policies. Your understanding and cooperation is greatly appreciated.

Cancellation Policy

24 hour advance notice is required when cancelling an appointment. If you are unable to provide 24 hours advance notice, you may be charged the **full amount** of your scheduled service. If you have prepaid for the service, the amount may not be refunded. If the service was not prepaid, the full service amount, if charged, must be paid at the time of your next scheduled appointment.

Failure to show for an appointment will result in a charge for the **full amount** of the scheduled service. If you have prepaid for the service, the amount will not be refunded. If the service was not prepaid, the full service amount must be paid at the time of your next scheduled appointment.

Gift Certificate Policy

If you want to spend your money on Skinology services, why not make it as easy as possible for you to do so? Skinology Gift Certificates can be purchased in the salon, by phone or online in any amount. Skinology Gift Certificates do not expire and are transferable.

Late Arrival Policy

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible to pay for the **"full"** session.

Same Day Appointment Policy

The online appointment scheduling cut-off is 8:00 a.m. each day. If you would like to schedule an appointment for the same day, please call (803) 764-1170 or (803) 479-1582.

Privacy Policy

We will not use any personal information you provide to us for any reason other than to provide you information on specials or events or for scheduling purposes. If we see a selfie you publish on a social media site, we may share that picture on our social media as we love to see happy clients on social media.

_____ _____

Date Client Signature

2231 Devine Street Suite 304 Columbia, SC 29205
(803) 764-1170